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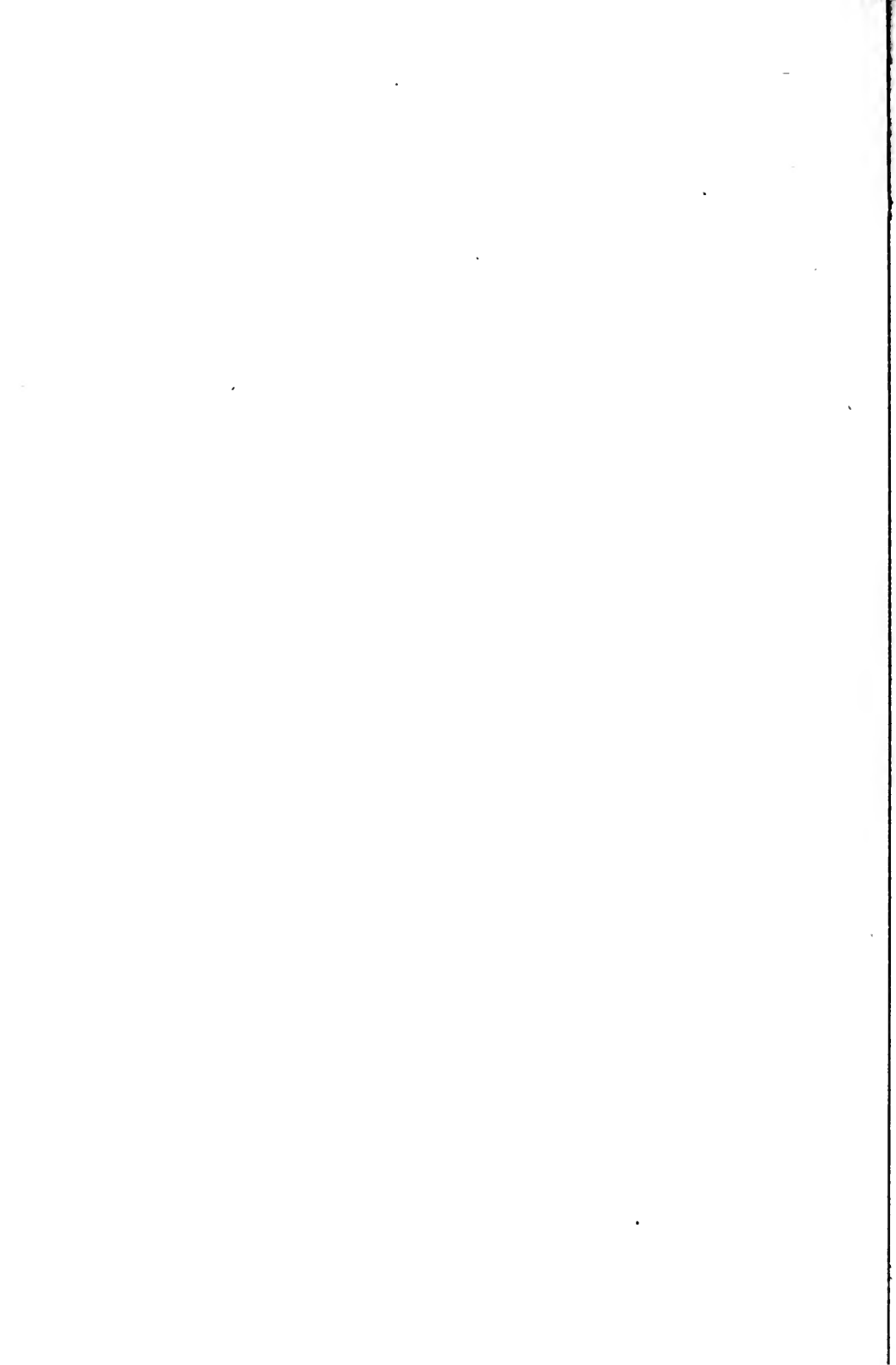
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Dr. Geo. M. Fox' Case of Trichophytosis Cruris.

JOURNAL

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Original Communications.

NOTE ON THE DEVELOPMENT OF TRICHOPHYTOSIS CRURIS.

BY

GEORGE HENRY FOX, A.M., M.D.,

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THERE is probably no parasitic affection of the skin occurring in this country, whose nature is so apt to pass unrecognized as the ring-worm or so-called *eczema marginatum* of the genito-crural region. The disease is not so rare but that it is likely to occur in the practice of any physician, and a note on one or two clinical features of diagnostic value may be appreciated by readers who are not specially expert in cutaneous affections.

Trichophytosis cruris usually begins upon that portion of the thigh with which the scrotum comes in contact, and the frequency with which the left thigh is found to be the starting-point of the disease, in males at least, is doubtless owing to the common custom of dressing upon that side. A reddened, scaly disc of circular or oval form may be noted at the outset, but frequently the patient is not led to examine the affected part until there has developed a reddened patch bounded by the outline of serotal contact. A slight pruritic sensation is now experienced, the patient being inclined to rub rather than to scratch the affected skin. The other thigh becomes affected shortly after the disease is established, and a somewhat symmetrical eruption results, although the patch upon the thigh first affected is almost invariably larger than that upon the other. The disease is observed to be most active at the periphery of the

patch, although *the abrupt and gradually advancing margin which is characteristic of ringworm of other parts is frequently wanting in trichophytosis cruris*. Frequently the border of the patch shows an eruption of discrete lesions of a papular, vesicular, or even pustular character, as is seen upon the left thigh of the patient, represented in the accompanying colored plate. The invariable situation of these lesions at the mouths of the hair follicles is indicative of their trichophytic character. At this period a diagnosis of papular eczema is very apt to be made, since many dermatological writers formerly laid stress upon the diagnostic point that ringworm has a marginate border, while eczema shades off at the margin into the healthy skin.

In a few days, however, the discrete lesions multiply in number, coalesce, and form not only a sharply circumscribed periphery, but often *a broad marginate band of a bright-red hue*, and an inch or more in width. During the extension of the patch, it is not uncommon to observe the development of small, annular elevated patches of inflamed skin of the size of a dime or quarter-dollar. These reddish "buttons" may be located upon the smooth or slightly scaly and pigmented skin, constituting the oldest portion of the patch, or they may develop just outside of its margin. One will be seen upon the left thigh in the case illustrated. The development of these circular patches, as well as the marginal band above mentioned, is accompanied by a decided increase in pruritus, which is often very annoying to the patient.

Another peculiar feature of trichophytosis cruris which I have repeatedly noticed is the sudden development of a line of lesions usually vesicular, *about three-fourths of an inch or more beyond the margin of the patch*: a band of apparently healthy skin being inclosed. This peculiarity, of which little or no mention is made by writers on the subject, is well shown upon the right thigh of the patient portrayed in the plate. The only explanation I can give of this singular progress of the eruption, so different from what is observed in ordinary ringworm of the body, is purely hypothetical. The deep-seated fungus may undermine the epidermis for a short distance, and then break through to the surface of the skin without raising an epidermic layer, as happens in the cases of *tinea imbricata*, or ringworm of the crotch and axilla, occurring in certain tropical climates. This explanation seems probable, in view of the fact that the inclosed band of smooth epidermis becomes transformed in a few days into an inflamed marginal band, such as we have seen to result from the multiplication and coalescence of discrete papular lesions. For example, in the case of the patient portrayed in the plate, this marginate band appeared on both thighs within a week from the time the water-color drawing was made, and the general appearance of the eruption was entirely changed.

NOTES ON PSORIASIS.¹

BY

R. W. TAYLOR, M.D.,

Surgeon to Charity Hospital, New York.

IN this brief paper I wish to call attention to an old and unaccepted view as to the etiology of psoriasis and to offer some conclusions as to its prognosis and treatment. No point in its history is more obscure than its etiology, since most articles written on the subject tell us what are not its causes, and none of them what they are. Long ago I was struck with the suggestion made by Erasmus Wilson, that psoriasis is "a manifestation of the syphilitic poison after transmission through at least one, and perhaps several generations." At the time I was inclined to ridicule the view, as indeed did most dermatologists, and it has since gained no upholders. I was inclined in those days to think that syphilis always showed itself in, and caused by transmission, definite and specific lesions. Larger experience and study have shown me, as well of course as others, that it may lead to lesions of nutrition, or, as they may be called, sequelæ, which are not specific in appearance or nature. With the view entertained by Wilson impressed on my mind, a dozen or so years ago, I began to observe for myself. In every case where it was possible, I collected facts as to the medical history of patients, of their brothers and sisters, of the parents of the patient, and as far as I could, about the grand-parents. Be it distinctly understood, I began the inquiry as a doubter and not anxious in any degree to confirm Wilson's theory. I will not inflict on the members a tiresome series of cases, but will give the general facts drawn from careful observation. But there will be nothing stated, let it be distinctly understood, which has not been observed and carefully weighed. Let me say right here that, in many cases, I could get no trustworthy information of the condition of the parents, in others where I could get a reliable history of them, I failed to convince myself that one or both had suffered from syphilis, but again, in fully twenty-five per cent of the cases, I convinced myself indubitably that one of the parents had been syphilitic. In the greater number of my cases, the father gave a history of syphilis, in a small proportion the mother had been infected. In none of these parents was the disease in an active stage, the infection having taken place from five to fifteen years before the birth of the child. Some of them had suffered severely; others had had mild attacks of syphilis, and strange to say, in all of them the lesions of the integument and mucous membranes had been the most prominent symptoms. In but one case had manifestations of the disease been present in the

¹ Read at the sixth annual meeting of the American Dermatological Society, at Newport, R. I., August 30, 1882.

parents as late as three years prior to the birth of the child which subsequently was the victim of psoriasis. In three cases, there was distinct transmission from father to child, and a reasonably clear history of syphilis in one case in the grandfather of the younger patient. These facts, carefully collected, I think warrant me in calling attention to the view of Wilson, which has been repudiated and indeed deemed scarcely worthy of mention by almost every writer of prominence. I don't wish to indulge in a piece of special pleading. I simply say my experience warrants me in the impression that antecedent syphilis in the parent, in whom at the birth of the child no evidences of the disease, beyond in some cases a condition of debility or poor nutrition, may have had some influence in the production of psoriasis in the offspring of that parent. We certainly must admit that there is some reason why only a few, say in general one, less frequently two, and exceptionally three children are psoriatic, while others are free from the disease. In all of my cases (I mean in which I obtained a history of syphilis in the parents) the psoriatic children have been the older ones, or those born at a time nearest the infection of the father or the mother. I have met with one undoubted case of hereditary syphilis in a girl (notched teeth, keratitis, etc.) whose brother born three years later developed psoriasis in his fifth year. I may add that there was no history of psoriasis in the ancestors or relatives of the child. I have been struck with the fact also, that where several children or persons of older growth of a family have been afflicted with psoriasis, the disease has manifested itself in consecutive subjects, and that it has not skipped one or more, appearing in later born children. The first seems to indicate that the causes which produced the disease in the two children did not exist in subsequent ones. Then considering that the mother had been syphilitic, we have presented to us, I think, food worthy of reflection. I think that in general psoriasis shows itself before puberty; some writers, however, think that it usually appears later in life. I have seen a case of a well-marked psoriasis in an infant two years old, and I am convinced that, in the majority of cases of the disease, some manifestations of it have shown themselves in early years. In many cases the eruption is so slight in early years as to attract no attention, being confined to a few spots on the elbows and knees, or on the trunk, and in consequence of the absence of itching it comes and goes in this limited form for years. Then later on, when a general eruption appears, the patient dates that period as the origin of his or her disease. I have many times established this fact by questioning patients and their parents. We are sometimes told that the patient never had the eruption until after vaccination, scarlatina, or other exanthemata, or acute dermal inflammation. The question arises, were not these inflammations the means of awakening a latent morbid tendency? I think, then, that

we can place psoriasis in the category of diseases incidental to the development period of the human subject. With the data at our command, it would be folly to attempt to draw conclusions. I think that the facts here stated are food for thought and should be incentives to observation by my worthy colleagues. Then at some future day we can pretty correctly determine the moot point as to whether syphilis has a more or less remote relation to psoriasis. I think I may mention the fact that in certain exceptional cases the papular syphilide presents appearances so closely resembling psoriasis as to be at least perplexing. Then again the indolent subacute course of the non-specific disease is very similar to that of the same syphilide. So much for etiology; now as regards prognosis. I think that our views as to the curability of psoriasis are susceptible of modification. We are taught that relapses are inevitable, and that Hebra's classical case of the psoriatic man who suffered also from hemoptysis, being the only person he ever knew of not suffering a relapse of his skin affection, has had too much influence upon us. It has certainly been the cause of a gloomy prognosis in hundreds of cases. Without burdening my hearers with dry details of illustrative cases, I will state concrete facts, vouching for their truth. I have almost convinced myself that, if psoriasis is treated early and persistently in the young subject, it may be cured. In several instances, the early eruption has been promptly cured by me; in none of them has there been a relapse in a period of six and eight years. I think that frequent attacks of the disease engraft on the skin a morbid tendency, or rather, expressed in a homely way, that the skin takes on a bad tendency, which may be even permanently engrafted on it. I should suggest this modification of our opinion as to prognosis of psoriasis—namely, that relapses are not inevitable, but that they are most severe and frequent in those cases which have been neglected or inefficiently treated in early life. From careful and prolonged observation I think I am able to affirm that a combination of arsenic and mercury (as in Donovan's solution) will yield better results in young psoriatic subjects than will arsenic alone. In old and inveterate cases, I think that the latter alone is our best internal remedy. My belief is strong that, if psoriasis is attacked in its early stages by efficient internal and external treatment, before it engrafts itself deeply upon the nutrition of the skin, it can be thoroughly cured. I may here mention the fact (as analogical evidence) of the persistence of the so-called syphilitic palmar and plantar psoriasis, when for any reason it has become chronic, and of its amenability to treatment if attacked early.

DISCUSSION.

DR. WM. A. HARDAWAY said that he was fully aware of the peculiar view taken by Wilson that psoriasis was a remote result of syphilis, but,

as Dr. Taylor had said, it is a theory which has not been accepted, and it seemed totally untenable. He inquired if Dr. Taylor acknowledged syphilis as the only cause of psoriasis.

DR. TAYLOR replied that he did not acknowledge or assert or state anything as a cause; he merely reported certain facts, and would let every one draw his own conclusions.

DR. HARDAWAY, continuing, said that it would then be very hard to discuss the question from such a stand-point. He recalled a case of psoriasis in which the disease first appeared at the age of sixty-five years. We know that hereditary syphilis does not occur so late in life; the age at which the psoriasis appeared, therefore, was against its hereditary character in this instance. He had seen it stated that it usually appears first at puberty, but he had seen it at all ages, and in some cases he had satisfied himself that it had been inherited. He recalled a series of cases in which a gentleman and his child, a sister of the father and her child, a brother and his children, in fact, almost the entire family (he could not recall the exact number) were subjects of psoriasis. This gentleman said that his father was free from the disease, but thought that his grandfather had it. With reference to the treatment, he would simply say that he had recently given chrysophanic acid internally in a few cases of psoriasis with good results.

DR. L. A. DUNNING remarked that he would merely state that from his own stand-point, he could not say that syphilis is ever the cause of psoriasis; he had simply no facts to offer in corroboration of that view. On the contrary, all know that the papulo-squamous syphiloderm takes on an appearance so very much like psoriasis that the most practised observer finds himself puzzled about the diagnosis. However, the two should be distinguished, and, with care, they can be, as the clinical history of the squamous syphiloderm is well-known, and is given in all the books. From the paper, he was at a loss to know whether Dr. Taylor takes particular pains to distinguish this disease or not. There are a great many causes which may produce what is called psoriasis; and for those who look upon a certain syphilitic manifestation as psoriasis, then syphilis may cause psoriasis. He regarded this view as a bad one to take, as it confounds symptoms with diseases. It would seem that this view before it could be accepted would require a good deal of thought, and would need to be established by a large number of cases and a more exhaustive paper than that which had been just presented.

DR. JAS. C. WHITE said that the paper appeared to him to indicate that the author had satisfied himself that syphilis is one of the antecedents of psoriasis. According to his own opinion, no two diseases could be more dissimilar. The whole course of the diseases, the fact that syphilis may occur primarily in a person suffering with psoriasis, the amenability to treatment, the contrast with other syphilitic manifestations, all show complete diversity. But if Dr. Taylor meant a coincidence, he asks whether psoriasis occurs after syphilis more frequently than other skin diseases—eczema, for instance.

DR. TAYLOR, interrupting, said that he did not offer any theories whatever, but merely submitted facts; and if others found the inquiry interesting, he would like them to pursue it further. Eczema is an entirely different question from psoriasis; it may be due to traumatism; he had never seen psoriasis so caused. He merely would say that in a

disease in which the etiology is so little understood, the cases he had submitted might suggest a possible explanation.

DR. WHITE said that he would like to ask Dr. Taylor with regard to the character or social standing of the cases he had reported.

DR. TAYLOR said that they were of all classes, from the highest to the lowest; both hospital and private patients were represented. He had observed certain facts, which he brought before this body in order that further light may be thrown upon them; the authorities give no cause, but state merely negations. Dr. Duhring, in his work, simply states that syphilis has nothing whatever to do with it.

DR. WHITE said this was precisely the point which he desired to bring out. Out of a certain number of cases, he would expect to find a larger number of cases of syphilitic parentage, owing to the social standing of the class which furnishes the greatest number of cases of psoriasis, than he would in the same number of cases of eczema, for instance; in other words, there would be a smaller number of cases of eczema with a history of syphilis than there would be of psoriasis.

DR. TAYLOR said that he simply stated the fact that in a certain proportion of cases he had found a syphilitic history, and would leave it for others to inquire into the cause or connection.

DR. WHITE asked if the reporter had always been satisfied with the history of syphilis. If a man sixty-five years of age has psoriasis, what can he tell about his grandfather? He further inquired were the cases taken in sequence, or were they selected?

DR. TAYLOR replied that he did not pick the cases; he had no desire to pick cases in order to present any theory, but he had reported the whole series of his cases, and had the complete notes of each case. He had not read them, as he did not wish to weary the Society; he simply presented his concrete facts.

DR. CHAS. G. SMITH remarked that there seemed to be a greater tendency from year to year to give syphilis a larger share in the causation of chronic skin disease. With regard to the question under consideration, he did not understand Dr. Taylor as bringing the view forward as a mature conclusion, but rather as a suggestion. It would seem that the fact that arsenic has such an influence upon psoriasis would lead to the view that it is not syphilitic.

DR. TAYLOR said that some syphilitic lesions are best treated with arsenic, as is well known. He would observe also that in the younger cases, Donovan's solution has more effect than in the older ones.

DR. A. R. ROBINSON said that he had asked all of his patients with psoriasis this question about syphilis, and in a considerable number he found it in the family; but he was satisfied that there are not a greater number of cases with syphilitic parents than he would expect to find in other skin affections, so that he would not conclude that it is a cause. Psoriasis occurs at all ages. There are many other points of difference between it and the papulo-squamous syphiloderma; there is not the proliferation of cells, etc.; and then, again, if it is syphilis, it is strange that it does not appear oftener on the palms of the hands, as syphilis so frequently does. He had not seen a case of psoriasis which had it in this situation.

He had found patients get well on arsenic and iodide of potassium quicker than with arsenic alone. He had given arsenic to a child for a

month with little effect, but after adding five grains of iodide of potassium to each dose, the child got well inside of a month. With regard to the possibility of external causes giving rise to psoriasis, he certainly had seen some cases caused by external irritation of the skin. In some cases, it has followed vaccination, appearing upon the identical spot of puncture, and, therefore, not due to some change in the whole system, but to a local disorder of the skin.

With reference to the supposed cause, he could not see any connection nor any evidence upon which to base the view that there is any connection between psoriasis and syphilis.

Dr. Roné finding that vaccination had been mentioned as one of the causes of psoriasis, stated that he would presently report two cases, and he remarked in this connection that he had never seen any such connection referred to in medical literature, and he had therefore prepared the notes of the cases for reading before this Association. With regard to syphilis, he had never been able to get any evidence that syphilis in the parent had anything to do with the generation of psoriatic children.

Dr. HEITZMANN said that it is hardly necessary to repeat that syphilis and psoriasis are entirely distinct, and so long as it is stated as a mere coincidence that in a number of cases there was a remote history of syphilis, it is all very well, but there is nothing to argue about. Why should not a syphilitic father have a psoriatic child? or one with any other disorder? He failed to see anything to prevent it.

Dr. PIFFARD said, that at present there were three different views of the etiology of psoriasis: 1st, the suboxidation theory; 2d, the parasitic view advanced by Lang; and, 3d, the syphilitic hypothesis, as mentioned by Dr. Taylor. Personally he accepted the first of the assigned causes—the suboxidation theory. The second need not be considered. Now, taking up the third, if we compare the course of psoriasis with the ordinary course of syphilis, there is no similarity; the diseases differ at almost every point, there is not one point in which they come in contact. Psoriasis, moreover, is a disease which has been known for many years and was accurately described in ancient times, the records, of which have come down to us. Syphilis, on the contrary, was not then known, certainly it was not accurately described. If we turn to the sacred writings, we find it stated in the New Testament that Christ healed ten cases of psoriasis; the English version says “leprosy,” but it is a mistranslation, psoriasis being the modern equivalent of the Greek term *λεπρα*, the word used in the original.

Now if syphilis did not have an ancient origin, as many believe, then certainly psoriasis could not have originated from it. The coincidence of the two diseases in the same individual has been noted by Dr. Hyde in a paper which will soon be read. Several cases had come under the speaker's observation, in which primary syphilis had occurred in a person already suffering with psoriasis, without being at all modified. He would hardly have expected that the two lesions of the skin, papular syphilis and later, the tubercular eruption, would appear associated with the psoriatic lesion, but it did so, and the latter steadily progressed and recurred from time to time.

Dr. Taylor brings forward the statement, that arsenic and mercury and Dr. Robinson that iodide of potassium, are useful in the treatment of psoriasis, of which there is no doubt whatever. The speaker had seen

distinct cases of psoriasis disappear under these remedies, and they were not cases of the squamous syphiloderm by any means, and under the care of another gentleman he had seen the lesions of psoriasis disappear very promptly from the use of large doses of iodide of potassium internally, externally, mercury sulphocyanide.

The whole discussion may be summed up by saying that (1) mercury and iodide of potassium are useful in psoriasis, and (2) that in a certain number of cases of psoriasis there is an antecedent history of syphilis; but not more so than in acne, eczema, or other skin diseases.

From Dr. White's remarks he inferred that he believed that syphilis is very common among the lower classes. The speaker's experience had been just the contrary, the hard chancre in males is more frequent in the upper than in the lower classes.

DR. HYDE said that he greatly regretted that he had not found the opportunity that he desired to complete the notes which he had brought with him, and upon which he proposed to base a paper on the coincidence of syphilis and psoriasis; although announced in the programme, and should have appeared in connection with this discussion, he would be unable to read it. As it was based upon facts observed by himself which had special interest to him, he would, however, state this much. He had had under observation two cases of inveterate psoriasis, both of which were unmistakably typical cases of the disease, and both of which were unmistakably affected with syphilis. One of them he had the opportunity of seeing but little of, but with the other one it was quite the reverse; for six years he had this patient under constant observation with every recurrence of the disease, and there were many of them. He was a very good patient and willing to follow out the experiments and instructions. He (Dr. Hyde) had not only become familiar with the disease itself, but also its peculiar course and appearance in this patient, when he contracted syphilis. Not only did the primary symptoms pass through a regular course, but at the proper period a skin eruption made its appearance. With this there was a peculiar efflorescence which was of great interest, exhibiting a mixed form. When the eruption first appeared it was abundant, covering the body all over, but it was an unmistakable psoriatic eruption. No difference could be distinguished from the former attacks; the palms of the hands and soles of the feet were spared; but at the same time he was afflicted with adenopathy and mucous patches and other familiar signs of syphilis. When the psoriasis declined it left an unmistakable syphilitic eruption.

DR. TAYLOR inquired of Dr. Robinson whether he had gone into the history of his cases of psoriasis with a view of ascertaining a syphilitic etiology?

DR. ROBINSON said that he had, and had found the co-incidence occasionally; but not, in his opinion, any oftener than in other skin diseases, and not nearly so often as he would expect to find in a similar series of cases of acne.

DR. TAYLOR asked if Dr. Robinson had looked for syphilis, and if he had, what was the percentage?

DR. ROBINSON thought that Dr. White had answered this very fully. Unless a much larger number of cases of antecedent syphilis could be brought forward than occur in other forms of skin disease, the argument cannot be sustained.

DR. TAYLOR said that he had submitted no argument, but merely cases, and had withheld his own view as to the etiology of psoriasis, and its relations to syphilis. He would say, however, that he utterly repudiates the suboxidation theory.

DR. HARDAWAY regarded the case reported by the President as an exceedingly interesting one; and inquired what was the period between the initial lesion and the appearance of the psoriasis.

DR. HYDE said that he believed that it was sixty-five days from the first appearance of the sore; his recollection was that it was fully four weeks from the time when the other eruption came out to the time when the papulo-lenticular syphilitic eruption was noted.

DR. TAYLOR said there was one fact with regard to treatment that should be mentioned. If a child is treated early and systematically, it can be cured, but if neglected and only treated occasionally it will keep on having relapses. Inveterate cases exist, because they were not properly treated in the beginning, and the skin has been allowed to take on bad habits.

DR. PIFFARD inquired the number of children treated, what was the percentage of cures, and how many were permanent?

DR. TAYLOR said that he could not state precisely at the moment, but he recalled four cases which he had cured by this method, which he still had under observation, and which have had no return of psoriasis for five or six years, and that he had treated many more, but those reported were those which he had been able to keep under observation long enough to report positively as to the results. The prognosis of psoriasis, as he has pointed out in the beginning, is usually regarded as very bad. He had tried to show that it is not hopeless if treated early and systematically; and he thought if mothers were told, that by following out the treatment carefully the child may escape further manifestations, it would be better for both patient and physician.

DR. HARDAWAY recalled a case sixteen years of age, treated successfully by chrysophanic acid, no mercury or arsenic whatever was given. Therefore, if a case will recover under local treatment exclusively with chrysophanic acid and green soap, we cannot draw any conclusions as to its constitutional character from the therapeutics of others treated with iodides. By giving remedies internally, we merely take a circuitous route to accomplish what we can do directly by local treatment.

THE PATHOLOGICAL ANATOMY AND THERAPEUTICS OF TUBERCULAR LUPUS.

1. The intradermic neoplasm of which lupus is constituted, presents some histological analogies to tubercle, but these do not suffice to establish the identity of the two products.

2. Experimental physiology unites with the results of clinical observation in differentiating lupus from the products of tubercle, and in displacing the former from the position it has hitherto held in the list of local tuberculous cutaneous affections.

3. Local measures alone are of any real value in the treatment of lupus. Those most approved of at present are linear scarifications and scraping. Cauterization by puncture, when properly indicated, may also be followed by the happiest results. It sets up a brisk inflammation which promoted a cure by modifying the vitality of the tissues in which the disease is propagated.—BASIN, *Thèse de Paris*, 1881.

TWO CASES OF ACUTE GENERAL PSORIASIS FOLLOWING VACCINATION.¹

BY

GEORGE H. ROHÉ, M.D.,

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THE occurrence of general eruptions after vaccination has been noted so frequently of late that the thought of impurity of the virus must have presented itself to many. Dr. Henry A. Martin has, however, recently shown² that such eruptions had been very often noticed shortly after the introduction of the practice of vaccination, and that, since the more frequent use of animal virus, these eruptions complicated the manifestations of the vaccine disease in a much larger proportion of cases. Dr. Martin quotes Willan, who speaks in a work on vaccine inoculation, published in 1806, "of a profuse and general miliary eruption as being noticed about once in fifty cases of vaccinia in the human subject," and from his own experience, corroborates very exactly Willan's approximative estimate of its frequency. The general roseolar eruption, whether diffused or occurring in spots or larger patches, supervenes sufficiently often that nearly every one having much to do with vaccination must have noticed examples. Behrend³ also speaks of urticarias, exudative erythemas, and eczematous eruptions as complications of the vaccine disease. A case of the latter (acute general eczema), apparently lighted up by the vaccination, recently came under my notice. The so-called "gangrenous vaccinia" which I cannot believe to have any relation with true vaccinia at all, but which I imagine to result from the inoculation of septic or decomposing matter, and which produces an ulcer, sometimes destroying all the tissues down to the bone, has been so frequently noticed during the past winter and spring that no extended reference to it is necessary.

Opportunity has not been afforded me to make an extended search into the literature of the subject, but I have hitherto seen no cases reported that bore any resemblance to two which have been lately under my care, and which I venture to briefly put on record.

CASE I.—J. W. C., a physician, 28 years of age, consulted me in February, 1882, with the following history:

¹ Read at the sixth annual meeting of the American Dermatological Association, at Newport, R. I., August 30, 1882.

² N. Y. Med. Record, April 15, 1882.

³ Archives of Dermatology, Oct., 1881.

His health had always been good, with the exception of a lymphangitis from a dissecting wound and an attack of catarrhal pneumonia during the preceding six months, from which he had entirely recovered. His nutrition was fair, but he has been somewhat troubled during the past two weeks with gastric irritability. He is also somewhat run down from over-work in the dissecting room. He has never suffered from any skin affection, or from any recognized manifestation of gout or rheumatism. According to the best of his knowledge and recollection, his parents, brothers, and sisters have also always been free from such diseases. About the middle of January, he had been vaccinated with fresh bovine virus, which failed to produce the characteristic vaccine vesicle. In eight or nine days after the inoculation, however, the spot became extremely itchy, red, and covered with white scales, which, on being rubbed or scratched off, were rapidly reproduced. A few days afterward, he noticed a number of small red papules covered with white scales, disseminated over the arms and thighs. The itching increased co-incidentally with a rapid spreading of the eruption. The spots enlarged by eccentric spreading of the primary eruption, and not by the aggregation of single papules. The base of the patches was red and infiltrated, and the covering of white scales very profuse.

On the 10th of February, when I was first consulted, the eruption, consisting of the various sized lesions characterizing the typical efflorescence of psoriasis, covered almost the entire body. The extensor surfaces of the forearms, outsides of the thighs, and sides of the trunk were thickly covered with psoriatic papules, spots, and larger patches, while the eruption on the rest of the body was less profuse. The palmar and plantar surfaces were exempt from the eruption, but the face was pretty thickly covered. Here the scales were constantly removed, and the efflorescence simply consisted of reddened papules and raised spots. The itching was so severe as to interfere seriously with the patient's rest. There was anorexia, slight fever, and marked lassitude. Some quinine had been taken, but without any favorable effect on the eruption.

I, at first, directed five-drop doses of Fowler's solution of arsenic thrice daily, with calomel ointment to the face to allay the itching. Under the arsenic, the itching and systemic irritation increased, and the disease continued to spread. After about a week the arsenic was discontinued, and the following mixture, which I have found of service in many cases of acute exudative affections of the skin, was ordered:

℞ Potassii acetat.,

Ext. taraxaci fluidiāā ʒ ss.

Aquæ fœniculi.....ad ʒ ij.

M. S. Dessertspoonful in half a pint of water four times a day.

In addition a daily hot bath, rendered alkaline with carbonate of sodium, was directed.

Under this treatment, the eruption at once began to improve, the redness, itching, and the production of scales decreased, and in three weeks the patient was entirely well. The dark pigmented patches of the skin, generally remaining after psoriasis, did not entirely disappear for nearly three months. The alkaline baths had also been taken during the arsenical course, so that the good effect of the treatment could not be ascribed to the local remedy alone.

CASE II.—M. W., white, male, nine years old, of Irish parentage,

was brought to my clinic at the City Hospital, April 17th, 1882. The boy was generally in good health, and neither he nor his parents had ever before suffered from any skin eruption. He had been vaccinated by one of the official vaccine physicians of the city a month before. The vaccination was successful. Bovine virus had been used. After the crust had fallen off, the spot became scaly and larger. Then small scaly spots appeared all over the body, and led to his being brought to the clinic.

My notes made at the time state that a psoriatic eruption in points and spots is disseminated over the entire body, being thickest on the lumbar region. The elbows are the seats of large red patches, thickly covered with white scales. There is also a patch as large as a dime upon the left cheek, and a number of smaller spots scattered over the scalp. The patient appears otherwise in good health, and does not complain of much itching.

He was placed on three drops of Fowler's solution thrice daily, and the following ointment, directed to be applied locally, after a thorough scrubbing with soap and water to remove the scales:

℞ Hydrarg. ammoniat..... ʒ i.
 Bismuthi subnit. ʒ ss.
 Ungt. petrolei..... ʒ i.
 M. ft. ungt.

Two months later, the eruption had entirely disappeared, but, when I last examined the patient, about the middle of July, I found several small scaly papules, indicating a return of the affection.

The rapid development of the eruption, and the excessive itching present in the first case reported above, caused me to hesitate in my diagnosis, but, after watching the case for a few days, there remained no further room for doubting that the case was one of psoriasis. In the second case, the diagnosis was clear from the beginning.

I entirely agree with the opinion so strongly upheld by Hebra and the Vienna school, that an eruption of psoriasis may be produced by any irritant applied to a skin predisposed to take on this disease, but the absence of cases in the literature, depending upon vaccination as an exciting cause, has induced me to report the above cases.

DISCUSSION.

DR. HEITZMANN said that this paper was clear, conclusive, logical; and especially the last statement, that in a psoriatic subject any irritation may produce psoriasis. The writer did not claim that there is any direct connection between vaccination and psoriasis; and it does not need discussion.

DR. HARDAWAY said that he had not seen any such occurrence of psoriasis after vaccination, although he had had considerable experience with vaccination. There are a number of eruptions which may occur—herpes, erythema multiforme, and eczema are often met with. There are three stages of development at which a vaccination eruption may appear: The first is during the period of irritation from the wound made by the lancet, which may cause acute local inflammatory trouble, or erysipelas;

the second stage is that in which the vaccine poison is working in the blood, when we may have an eruption, just as we may have a medicinal rash from introduction of certain remedies into the blood; in the third stage, during the period of pus formation, there may be an eruption due to something like septic poisoning. With the latter he had seen cases of purulent otitis media, thus proving a septic influence at work.

DR. JAS. C. WHITE asked if the first case was followed by prolonged pigmentation of the skin.

DR. ROHÉ replied that it probably lasted for three months before it entirely faded. The primary eruption did not last more than six weeks, the largest not being over the size of a silver dollar. There were larger areas of aggregation of the primary eruption, but the single lesions did not exceed this size.

DR. WHITE asked if this amount of pigmentation is common in psoriasis?

DR. ROHÉ believed that a dark slaty pigmentation always had appeared and remained for some time in the cases he had treated, but it remained in this case for two or three months, the skin finally resuming its normal appearance.

DR. WHITE regarded this amount of pigmentation as more suggestive of lichen ruber than psoriasis, which is rather an uncommon condition of the skin. With regard to the question of arsenic, he inquired how long was it used, and why was it discontinued?

DR. ROHÉ said that it was given only for one week. The reason it was stopped was because it made the patient worse. He was an intelligent person and a physician, and he said that he must have something else, as the arsenic disagreed with him; he could not sleep at night, etc. He was then put on the other treatment.

DR. TAYLOR considered the observation with regard to the lighting up of psoriasis by other skin diseases as in a measure correct; he had seen it in case of scarlet fever, also in measles; he had seen a child fall out of a canal boat into the dock, and a slight fever with psoriasis follow. He thought that a mere congestion of the skin may be sufficient to start the disease, or any ephemeral disturbance of the circulation might cause it.

DR. PIFFARD said that with regard to the use of arsenic in psoriasis he had seen remarkable results; he had seen the skin almost entirely clear off and the redness disappear before the patient took the second dose. But the patient took a large dose—a teaspoonful of Fowler's solution—by mistake. The patient was bloated up, and had a bad time, but the eruption disappeared. He believed such an effect could be often produced, if patients could stand the large doses of arsenic.

DR. WHITE said that he had seen psoriasis change very rapidly in the course of a week, but not in the first week.

DR. PIFFARD said that experiments made in England by Ringer and Murrell show that the giving of large doses of arsenic to frogs would cause them to shed the entire epidermis.¹

DR. HYDE said that at the conclusion of the small-pox epidemic last season, he was visited by the Health Officer of Chicago, who brought with him a young lady, showing a typical psoriatic eruption covering the arms, elbows, and upper portion of the body. She gave a history of no disease

¹ Article published in the Journal of Physiology.

prior to vaccination, and the appearance of this disease soon after. The health officer said that out of fifty or sixty thousand cases of vaccination, this was the only case he had seen of psoriasis. The speaker was only surprised that there had not been more. If we take the statistics of psoriasis, and compare them with the enormous number of people who have been vaccinated, it will be remarkable that there have not been more cases of this kind falling under our notice. In this connection he recalled the case of a lady who made an appointment with a dentist to take chloroform and have some teeth extracted. She came at the appointed time, and asked to have the operation postponed, as she did not feel well. She left the room, and fell dead on the steps. If she had taken the anæsthetic, there might have been another death from chloroform reported.

DR. ROHÉ said that no doubt more cases of psoriasis following vaccination have occurred that have never been reported, and he had been surprised that he could find no record of such cases. With regard to the remark of Dr. Taylor, referring to the appearance of psoriasis after scarlatina and measles, he said that they were not analogous, because in such cases there was present a general hyperæmia of the skin; he would merely say that in the first case there had not been a general hyperæmia, because the vaccination had not been successful.

SYPHILODERMA PAPULOSUM CIRCINATUM.¹

BY

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THERE is a form of papular syphilitic secondary eruption, which, while it has received passing notice at the hands of numerous syphilographers, has not had given it the attention its peculiar characters deserve. I refer to the eruption that has, as its starting point, the large, flat papular syphiloderm, and to which the name heading this paper has been given by Dr. George H. Fox (Photographic Illustrations of Cutaneous Syphilis, p. 63, pl. ix.). Its peculiar feature is its centrifugal extension by a narrow border of elevation; while its central portions nearly or quite return to their normal limits as the process extends, very much as occurs in *tinea circinata*. The lesions differ essentially from the well-known annular or circinate eruption of papulo-tubercle so constantly present as cutaneous manifestations of late secondary and tertiary syphilis; for while these are nearly always expressions of the disposition of late syphilis to group its lesions in a circular arrangement, even at the moment of their development and at distinct intervals of space, so that

¹ Read at the meeting of the American Dermatological Association, September 1, 1882.

each group will represent a number of separate lesions, simply obeying the law of their distribution: the syphiloderma papulosum circinatum invariably begins in a single lesion, the papule, the location of which will correspond to the centre of the spreading lesion. All syphilographers describe the tendency of the flat papular syphiloderm to become depressed in the centre, and many of them describe phases of the process we are now considering. Bumstead and Taylor refer to one of these when they speak of examples of the flat papular syphiloderm, the margins of which "become elevated into distinct rims," or where an "annular crust of a dirty-yellow color may occupy the periphery of a papule;" and, again, where they say "not uncommonly in the retrogressive stage of these papules, particularly in late eruptions, absorption of the centre of the lesion occurs, leaving a ring which may be scaly, and which is itself finally absorbed without showing any tendency to centrifugal increase" (Venereal Diseases, p. 527). They assign the lesion to the middle and late secondary period of syphilis. George H. Fox (loc. cit.) enters more fully into the description of the lesion. "When the large, flat papules do not coalesce into scaly patches, they frequently tend to increase in circumference and present quite a different appearance. The centre of the papule becomes depressed as the elevated margin enlarges, and in this manner a circinate lesion is developed. Sometimes the surface of the papule becomes moist and presents an opaline or diphtheritic appearance, somewhat similar to the condition which is observed in mucous patches of the lips. The elevated margin of the disc is extremely apt to be eroded, and generally a thin, dark crust forms at the edge of the papule. . . . Sometimes the crust is yellowish, thick and friable, circular or crescentic in form, and with an inclosed area presenting a smooth surface, and a dull-crimson hue." Jullien (Maladies vénériennes, Paris, 1879, p. 703) likewise devotes a number of lines to this form of eruption which he illustrates with a very poor woodcut; he also notices a peculiar feature of the eruption, the tendency of the lesion to form two or more concentric circles ("Syphilide en Cocarde"). Kaposi (Syphilis der Haut und der angrenzenden Schleimhaut, Tafel xxxii.) figures a "syphilis cutanea annularis seu orbicularis" that corresponds to the lesion I am discussing, excepting that his plate represents both by the grossness of the lesion and the apparent scar formation, an advanced stage of syphilis, and would be more appropriately classed as papulo-tubercular or tubercular circinate syphiloderm. The lesion, the history of which I propose to write, belongs to the period of secondary syphilis, and may develop at any time from three months to eighteen months after the appearance of the initial lesion. It is essentially dependent upon the large, flat, papular syphiloderm, and the period of its evolution corresponds to that of this form of eruption. It affects the sexes equally,

and for the most part young adults. At my clinic, which includes a large number of persons of negro blood, the eruption appears to especially prevail in colored individuals. As is the case with syphilitic eruptions, one has usually the opportunity of studying its different phases upon the same patient. In its milder and more limited development, it affects preferably the face and neck, but when extensive, no part seems to escape it: back, breast, belly, thighs, arms, hands become invaded. Where the onset is acute and the eruption copious, fever may be present, and the lesions may form with almost the rapidity of those of the eruptive fevers. The lesions appear as bright or dusky-red discs, but little elevated in comparison to their breadth, and varying in size from that of a small pea to a diameter of two centimetres and more. Some remain without further development, or, within two or three days begin to desquamate in thin, fine scales, beginning at their peripheries. This desquamation either exposes a dry, smooth, reddened, and flattened elevation, or a moist surface which speedily forms a thin, straw-colored, or brownish scab, flattened and depressed towards the centre. After some days, these scabs fall off and leave pigmented spots. While these changes are going on in some lesions, others exhibit a more curious but less intense activity. While the peripheries of these papules show a scanty, fine desquamation, their central portions gradually sink down to the level of normal skin, and their borders extend centrifugally. A short interval suffices to convert the former papules into unelevated central areas, surrounded by narrow but abrupt borders of elevation, forming continuous rings of infiltration and continually throwing off fine scales. Rarely the eruption may be limited to a half-dozen of these spots, irregularly scattered over the face, neck, and shoulders.

The color of the central area will now be of a dusky-red color, slowly fading to a duller hue; while the border will be of a darker and more characteristic tint. The central area now continues to grow larger by the extension of the slightly elevated border, and all resemblance to the original papular lesion is lost. Instead, there is presented an appearance strongly suggestive of severe tinea circinata, which, indeed, it may so closely simulate that, without the previous knowledge of the patient's syphilis, the lesion may, upon superficial examination, be mistaken for ringworm. The elevated border will present a continuous narrow line of a slightly beaded appearance, and will throw off a fine branny desquamation. The central portion of the patch will usually resume its normal surface and thickness, but there will remain the deeper pigmentation; while its size will increase, and its shape will undergo modifications, altering the originally circular outline. In negroes, the ordinary pigmentation of the patches will be replaced by a simple increased intensity in the normal darkness of the skin.

These patches may reach a diameter equal to that of a half-dollar, and by the confluence of several, great irregularity of extent and outline may be attained. I have never seen any patch larger than the size just mentioned, nor do I know to what extent they may proceed if uninfluenced by treatment. It is likely, however, that spontaneous involution would destroy the patch before a much larger extent could be gained. In many patches a curious recrudescence occurs in their centres, whereby a new papule forms, and immediately proceeds to follow the course of its predecessor in extending peripherally, though, it is true, the extending border rarely forms a complete circle, but rather a segment of greater or less size, and not so sharply defined as the first one. Sometimes a third papule may develop within the pigmented inclosed space, and proceed to



extend in the same centrifugal manner. This photograph of a young negro man, whose initial lesion dated back only three months, the indurated remains of which were still to be detected, shows fairly well this tendency, as well as the extent of the separate lesions.

But small provocation is required to convert these lesions into mucous patches, and when the axillæ or groins are invaded, they readily become such. In a young woman, a negress, syphilitic eighteen months, the papular circinate syphiloderm developed within the buccal cavity, where the lesions, immediately becoming mucous patches, adopted the centrifugal extension, the narrow border assuming a pale opaline aspect. Unlike the usual course of syphilitic cutaneous eruptions, this form,

more especially when the rapid and excessive exfoliation of the epidermis lays bare the cells of the Malpighian layer, with the result of forming thin peripheral or general crusts, is often accompanied by a considerable amount of itching, as may be seen from the scratch-marks often present.

These lesions are apt to be mistaken for *tinea circinata*, *psoriasis*, or *erythema multiforme*. In the absence of a satisfactory history of the case and of a microscopic examination, this syphiloderm, when perfectly developed, may be perplexingly like ringworm. The spreading border, however, while delicate, is usually more sharply defined than in ringworm; while the color is usually of a deeper brownish shade, though the coloration of ringworm may frequently, especially in persons of dark skins, closely resemble that of syphilitic eruptions. The presence of itching will not serve a very good diagnostic purpose in these cases, since in the syphiloderm there is usually just about the same degree of itching as there is in the ringworm. Commonly the coexistence of a syphilitic history and of undoubted syphilitic symptoms will indicate the true nature of the disorder.

A microscopic examination of the epidermic scales will at once serve to exclude ringworm from consideration. *Psoriasis* differs from the circinate papular syphiloderm in the coarseness of its scales, the slower evolution of its lesions, its preferable location on extensor surfaces, the character of its concomitant symptoms, and the history of the patient.

The analogies of certain forms of *erythema multiforme* with this syphiloderm are sometimes great. So far as concerns the lesions themselves, the formation of the annular border is quite the same in each. In *erythema annulare*, the eruption is preferably upon the backs of the hands, feet, forearms, and legs, the face and neck; while in the syphiloderm, the breast, body, and face are most frequently affected. *Erythema annulare* shows a predilection for certain seasons, as spring and fall; is transitory in duration; is without the coppery color of the syphiloderm, and shows in its lesions a tendency towards blood extravasations, a less sharply defined transition from the central to the peripheral portion, and runs through its phases more rapidly than the syphilitic lesion. Very rarely *erythema annulare* may present a moist surface, over which a thin scab gathers, and then the resemblance to the moist form of this syphiloderm may become very close. Attention to the symptomatology, history, etc., will lead to a correct conclusion. This eruption, finally, is to be distinguished from annular lesions of late syphilis—the papulo-tubercular and tubercular eruptions that assume a circular or partly circular arrangement. Nearly all eruptions of late syphilis resume the annular distribution, but each circle will be observed to represent a compound lesion, composed of a group of papulo-tubercles or tubercles, each having been formed separately; while the circinate papular syphiloderm always

springs from a single lesion. In the former, the lesions are circularly arranged without being in contact; while in the latter, the peripheral border forms a continuous line of less decided elevation. It is, moreover, much less slow in its course. In the unusual event of a papulo-tubercular or tubercular lesion of late syphilis, following a centrifugal enlargement, as in the earlier papular syphiloderm, and as is represented in the already-mentioned plate of the atlas of Kaposi (see also Plate xxxi.), there can be no doubt that the lesions depend upon the same trophic influence, and that their anatomical differences are such only as those indicated in the clinical terms papule and tubercle. The later lesion would be appropriately denominated syphiloderma tuberculatum circinatum.

ACNE ATROPHICA OR LUPOID ACNE.

BY

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THE eruption to which attention is here called is one which not infrequently passes unrecognized, and one which has received very little mention in works upon diseases of the skin. Cases of it are, however, by no means rare, the following three striking examples being all observed in private practice within a period of about two years; while a number of others have presented themselves before and since. The importance of a correct diagnosis of this eruption can hardly be overestimated, as it is most commonly mistaken for one of the lesions of syphilis; it is also peculiarly rebellious to any but a rightly directed treatment. The characteristics of the eruption can be best judged from a brief report of the cases:—

CASE I.—Mr. Charles —, aged forty-five, a spare, rather nervous gentleman, stated that he had always enjoyed good health, with the exception of what he designated bilious headaches. He had six healthy children, all living, and with no eruptions. He presented no physical signs of disease, and his bodily functions appeared to be perfectly performed; the bowels acted freely; there were no stomach symptoms, except that very rich food disagreed; the tongue was slightly coated and pale; the pulse 66; sleep good and refreshing.

About ten years previous to his first visit, March 23, 1880, the eruption had first appeared upon the forehead, just below the margin of the scalp, and since that time he had never been free from some lesions, generally about a dozen or so points existing at the same time upon some portion of the face and neck. The character of the eruption had remained the

same from first to last, and the earlier lesions resembled those then present and active; while much of the forehead, the temples, the sides of the neck, and, to a slight extent, the cheeks were the seat of scars of previously existing points of disease—scores or even hundreds in number. These cicatrices were all of the same character—depressed, sharply cut, all about a quarter of an inch in diameter, and inclined to be circular; the older ones were paler than the skin; more recent ones were more or less stained.

The eruption which was then present and in active condition consisted of between one and two dozen red, slightly hard, inflammatory masses, one quarter of an inch or less in diameter, some of them presenting crusted summits, others pustular, and others yet apparently solid. These were all elevated a little, and had a moderately inflammatory halo; they were somewhat tender on pressure, and were apt to give annoyance by itching, and some presented torn summits. They were scattered principally on the forehead and temples, but some few existed in the scalp and side-whiskers.

He was given a little alkali with a bitter infusion, and a calamine and zinc lotion, for a week, and, when next seen, the lesions and the scars were so strongly suggestive of syphilis, that another careful study of the case was made. Absolutely no corroborative history could be obtained; but he was nevertheless placed upon a mixed treatment of mercury and iodide of potassium, combined with iron and bark. This was continued for six weeks and in increasing strength, but not only with no beneficial effect, but with a considerable aggravation of the eruption.

He was then placed upon a mixture containing acetate of potassium, tincture of nuxvomica, and dock root, with the local employment of an ointment of bismuth and a little white precipitate. The change in the eruption under this course of treatment was most marked and satisfactory; the lesions lost their inflammatory element, and began to disappear. In a few weeks, there were left only the scars, similar to those previously formed, and, when seen a year afterwards, it was recorded that the eruption had remained absent from all portions, and that only cicatrices were visible.

CASE II.—Mr. William —, aged forty-eight, applied to me December 31, 1881, for the treatment of an eruption affecting mainly the nose and left cheek. He was in apparently good health, bowels regular, digestion good, tongue clean, pulse 66. Eighteen years previous to his visit he had had a similar eruption upon the forehead, along the margin of the hair, and upon the temples, which had left scars similar to those recently formed: about the same time he had had points of eruption between the shoulders. These former lesions seemed to have ceased to appear for some time, and the eruption for which he came began first to develop during the previous summer.

When first seen, the nose was generally reddened, and on the right side near the extremity, and also on the left cheek, were several red, inflamed points, moderately pustular and crusted; upon the left temple there were also several similar pustules, and a few on the back between the shoulders. Along the upper portion of the forehead were a number of depressed, roundish cicatrices, a quarter to a third of an inch in diameter, and others similar on the left temple; there were also some upon the nose, and one large one in the centre near the tip. All these scars had

formed from inflamed points, similar to those present, which came and went slowly.

He was placed upon the same internal medicine as the former cases, and locally was given a lotion of sulphuret of potassium, zinc, and rose-water. One month later, it was recorded that most of the eruption had disappeared, although he had been a little irregular with the medicine. Two weeks later, no inflammatory elements were present, and the scars were becoming pale. Two weeks later still, it was noted that there had been a return of the eruption in the shape of a single, small, inflamed point on the right side of the tip of the nose which was crusted, and exhibited a hole when this was removed; there was also a small lump on the left side of the nose, but none on the forehead or elsewhere.

CASE III.—William T. —, aged twenty-seven, had had an eruption of acne on various portions of the face for a number of years, but it had not caused permanent scars until the past three or four years, when the character of the eruption changed somewhat. His general health was reported as good, with a slight tendency to constipation, and a pale and lightly coated tongue.

The principal location of the eruption in this case was the forehead which was covered with inflamed and indurated points, many of them ulcerated and many scratched. Between them were many small, roundish, depressed scars, suggesting syphilis or small-pox: the lesions present and the cicatrices resembled exactly those described in the two preceding cases.

REMARKS.—Although I have not made any microscopical studies in these cases, to demonstrate that the lesions were connected with the sebaceous glands, I have no hesitancy in regarding the eruption under consideration an acne, because of the clinical features presented, the history of the cases, and the ease with which the condition yields to ordinary acne treatment. I do not, however, place these cases in the same group as those instances of acne simplex in young persons, where there is often more or less scarring in connection with the ordinary inflammatory pustules of this and acne indurata; in these instances the scarring results from the direct destruction of tissue by the suppurative process.

In the cases under consideration the conditions seem to be different. This form of eruption is commonly seen in more advanced life; the process is a very chronic one, the grade of inflammatory action is a very low one, and the production of cicatricial tissue seems to be rather the result of altered nutrition and absorptive action than from the severity of the inflammation.

Whether the process is allied to lupus, I cannot state; it has sometimes been spoken of as follicular lupus, but I doubt the propriety of classing it as such, inasmuch as the line of treatment required is so radically different from that called for in this latter disease; no true lupus nodules are ever seen. Certainly it has no relation to syphilis, although the lesions and the scars suggest it most forcibly.

The eruption seems to be more common in men than women, although I have observed it a number of times in females.

Reviews.

MANUAL OF DISEASES OF THE SKIN. WITH AN ANALYSIS OF 8,000 CONSECUTIVE CASES AND A FORMULARY. By L. DUNCAN BULKLEY, A.M., M.D., Attending Physician for Skin and Venereal Diseases at the New York Hospital, Out-Patient Department, etc., etc. New York: G. P. Putnam's Sons.

TRULY it may be said that of the making of "manuals" there is no end. The genius of modern medical literature seems to manifest itself in extremes; either in the endeavor to abridge, condense, and present essential details in the most compendious form, or else to enlarge, elaborate, and exhaust the subject in a bulky, encyclopædic shape. The principal objection to the former class of books is that they are too superficial in character; they give the student only a smattering of knowledge, while furnishing him with the pretext for neglecting the hard and laborious work necessary for the thorough mastery of the subjects treated upon. But whatever may be thought of the practical utility of hand-books designed for the student and general practitioner, it must be conceded that the work before us is one of the best of its class.

In noticing a work of this character, regard must be had to its object and purpose. It does not pretend to offer novel and original views for criticism, but aims to present in an abridged form the accepted views of standard authorities upon the subjects of which it treats. For the preparation of such a work, the power of accurate condensation—a condensation which shall attain brevity without sacrificing clearness—is requisite. Gauged by this standard, Dr. Bulkley's Manual of Diseases of the Skin fulfils in the main all essential conditions. Both in subject matter and in the method of its arrangement it leaves little to be desired.

After a preliminary chapter devoted to the anatomy and physiology of the skin, the subjects of ætiology and diagnosis receive brief consideration. A chapter is devoted to an analysis of 8,000 consecutive cases, showing the relative frequency of diseases of the skin in this country. The classification, which is a modification of Hebra's, is already familiar to the profession through the author's numerous publications. We notice that syphilis is included among the exudative or inflammatory affections instead of the neoplasmata, with which it has always been classed. The author has coined a new term—*dystrophia cutis*—to express a condition which has always been recognized and is described by him as *atrophia cutis*. Thus, he defines *dystrophia cutis* as a "trophic disturbance of the skin, due to diseases and injuries of nerve trunks. The most commonly known form is the erythematous state, or 'glossy skin' seen after injuries of nerves" (p. 100); while (p. 238) *atrophia cutis* is defined as "a more or less general condition, such as occurs in connection with certain other diseased states, and also following injuries of nerves—the glossy skin of writers." The introduction of new terms in a nomenclature already overburdened with unmeaning and obscure words is to be deprecated—the more especially since the etymology of the new term does not convey a satisfactory *raison d'être*.

The various diseases of the skin are then described in a systematic manner,

with brief references as to their differential diagnosis and suggestions as to treatment. The whole is supplemented by a chapter on Diet and Hygiene and quite an extensive Formulary.

The paper, type, and printing are in the best style of the well-known publishers.

DISEASES OF THE SKIN. By LOUIS A. DUHRING, M.D. Third Edition. Revised and enlarged. J. B. Lippincott & Co. Philadelphia, 1882.

IF any proof were needed to attest the value of Dr. Duhring's treatise on Diseases of the Skin, the fact that a third edition has been found necessary in but little more than a year after the publication of the second, would be sufficiently corroboration. The merits and intrinsic worth of this work, however, are so universally acknowledged that its practical success was a foregone conclusion. Following so closely in the footsteps of the preceding edition, one would expect to find this but little more than a repetition or republication. Upon a perusal, however, this supposition is found groundless. On the contrary, the volume has been thoroughly revised and somewhat enlarged. In all, the work has been increased forty pages.

The chapter on the anatomy and physiology of the skin has been entirely rewritten and enlarged, embodying in a condensed and abbreviated form all our present knowledge on these subjects. The value of the work has been enhanced by the occasional citation of cases illustrating the rare forms of disease. The subject of therapeutics has received its full share of the revision, and embraces all recent advances made in this branch. The whole work has, in fact, been critically revised, new matter appearing on almost every page. In its classification, arrangement, and general features, this last edition is similar to its predecessors. In one particular only do we find a change—*molluscum sebaceum*, which appeared in the former edition among the disorders of secretion, has, under the name of *molluscum epitheliale*, been removed to the class of hypertrophies. The work as a whole is complete, and brings the subject of dermatology up to the present date.

Emanating as it does from a broad-minded dermatologist, and based as it is upon the extensive personal observations and experience of the author, as well as being replete with references to the researches and studies of other writers, the work, as an exponent of the subject of dermatology, cannot be too highly commended.

MOSQUITO BITES.—Dr. Jennings (*Lancet*, February, 1822, 471) states that a one-tenth-per-cent solution of atropine instantly relieves the itching.

PEPPERMINT OIL IN HERPES ZOSTER.—Dr. Meredith, of Birmingham, Eng., finds that peppermint oil applied locally, is capable of rapidly allaying the pain of herpes zoster.—*New Remedies*.

Selections.

PITYRIASIS CIRCINATA AND MARGINATA, AND ITS MYCODERM.

We outline the more important statements from a paper on this subject, in *Ann. de Dermatol. et de Syphilolog.*, for January, by M. VIDAL, Physician to the Hôpital St. Louis. Paris:

There are five well-recognized parasitic affections of the skin, viz.:—

1. *Pityriasis versicolor* (chromophytosis), produced by a fungoid organism discovered by Eichstadt—the *Microsporon furfur*.

2. *Erythrasma*.—This is a contagious eruption, most frequently met with on the groins and axillæ, in the form of well-defined circular spots, resembling pityriasis rubra. The most marked peculiarity of its parasite—*Microsporon minutissima*—is denoted by the name.

3. *Favus*.—This affection is due to the *Achorion Schönleini*.

4. *Trichophytosis*.—Caused by the *Trichophyton tonsurans*, discovered by Gruby and Malmsten.

5. The organism detected by Malassez in the scales of pityriasis capitis and described by him under the title *champignon du pityriasis simple*. It is characterized (1) by the absence of mycelium-tubes, and (2) by the varying outline of its spores, some being round and others oval. They measure from 5-1000th to 2-1000th of a millimetre in length.

These spores, as yet unclassified by naturalists, are of very common occurrence in numerous skin affections, and even in healthy subjects, whence M. Vidal calls them spores of the *Torula vulgaris*.

To this list Vidal adds the following description of the *Microsporon anomæon*. This parasite, discovered in a particular form of pityriasis circinata et marginata, is perfectly well-defined, and the affection it causes is easy of diagnosis.

The facility with which the disease is cured and the extreme minuteness of the fungoid growths, requiring the highest powers of the microscope for their detection, will account for their having passed so long unnoticed.

The rounded spores of these organisms average 1-1000th of a millimetre in length. Many are much smaller, and the largest seldom attain a length of 3-1000th.

The chief characteristics of this mycoderm are:

(1) Besides its diminutive size, the marked irregularity of its outline—whence the name *Microsporon anomæon* or *dispar*.

(2) Its arrangement in circles around the epithelial cells. The spores are also unevenly distributed, in groups or masses, over and between the cells so as apparently to destroy the continuity of the latter by pushing them apart.

(3) The rare occurrence of the spores in chains or “chaplets,” and the small size of the latter when they do so occur.

(4) The complete, or almost complete, absence of mycelium.

The special habitat of the *Microsporon anomæon* are the cells of the superficial and middle layers of the epidermis, which it undermines and exfoliates, thus producing a branny desquamation. But M. Vidal has discovered that it also infests the orifices of the hairs, whose bases are enveloped in a sort of white

sheathing, formed by an accumulation of spores and epithelial debris. The latter appearance is chiefly noticed in the beard and upon the face and neck. The hairs themselves, including their follicles, remain, in every case, entirely untouched by the disease.

II. Symptoms of *pityriasis circinata et marginata*.—The eruption produced by the *Microsporon anomœon* makes its first appearance usually on the trunk, but sometimes on the arms or thighs in the form of very slightly elevated, irregularly scattered small red spots. The surface is dry, and covered by bran-like scales, which are easily rubbed off.

These spots increase in size but slowly, becoming in a fortnight about as large as a ten-cent piece, and taking a month to reach the dimensions of a quarter-dollar. In a few cases they are larger, and some are of an oval shape. In certain parts, as the axillæ and groins, they merge gradually into one another, forming blotches which take on the characteristics of *pityriasis marginata*.

Those which remain discrete assume a circular form, the borders extending while the centres heal. Their edges are light-red or yellowish, and exhibit a furfureous desquamation. This is the genuine *p. circinata*.

When the disease under consideration has lasted for several months in the regions of the groins or axillæ, it may give rise to a more intense irritation, to an intertrigo, or even to an eczematous eruption, thus constituting one of the varieties—albeit the mildest—of that complicated affection described by the illustrious Hebra under the name of *eczema marginata*.

Pityriasis circinata is accompanied by a certain amount of itching, which varies according to the nervous constitution of the patient. This symptom is most troublesome when the disease is seated in the groins or axillæ.

Vidal has frequently known the complaint to last three or four months. In one case it lingered nearly half a year.

III. *Differential diagnosis from some allied diseases*.—A. *Pityriasis rosea* has the same bran-like desquamation and the same rose-red or yellowish spots as *p. circ. et margin.* But the former exanthem only comes out in spring-time, progresses regularly, and has an average duration of from four to six weeks, never exceeding two months. It uniformly commences on the breast or back, extending gradually from the median line in either direction, and spreads over the limbs *symmetrically*, in which latter situation the eruption may be in full activity, while it is healing spontaneously on the trunk. Its decline is marked by the same symmetry and regularity. On the other hand, the pityriasis caused by the *Microsporon anomœon* pursues the capricious course characteristic of parasitical affections in general. It begins sometimes on the body, sometimes on the limbs, and may last for several months. In cases of doubt, the microscope is the final resort. Diagnosis is positive if the *Microsporon anomœon* be detected; while *pityriasis rosea* will reveal only the *torula vulgaris*, which, as already remarked, is present in all cases of cutaneous desquamation.

B.—*Chromophytosis* is readily distinguished by its yellow or yellowish-brown color; and, moreover, appears in blotches, varying in size, and which cannot be mistaken for the circular spots of *pityriasis circinata*. Diagnosis is easy, except when the eruption occupies the axillary and inguinal regions, and assumes the form of *eczema marginatum*. In this case, not only will well-marked chromophytosis be found upon other points of the body, but the microscope will settle the matter by bringing into view the *Microsporon furfur* of Eichstadt, with its well-developed spores and abundant and characteristic mycelium.

C.—*Erythrasma* is of a deeper-red color than *p. circinata*, and only rarely

assumes a circular form, appearing in large or small blotches, covered with furfuraceous scales. It is of much longer duration, in some cases persisting for years.

Microscopically examined, its parasite is distinguished by a mycelium, composed of very numerous and extremely fine filaments. As already observed, no such structure has been made out in connection with the *Microsporon anomæon*.

D.—As to *trichophytosis* (ringworm), its circular form is the only feature in which it bears the slightest misleading resemblance to the complaint treated of. All its other characteristics are such as to make the diagnosis certain. The *trichophyton tonsurans* is at once differentiated by its microscopic appearances.

IV. *Etiology, prognosis, and treatment*.—M. Vidal has never known a person over forty years old to be infested by the *Microsporon anomæon*. In the cases he has observed, the patients' ages have ranged between six and one-half and thirty-six years.

He has treated more females than males for the affection. Whether this is because members of the fair sex were more willing to come under his care, or whether it is owing to the greater delicacy of their skin, he does not venture to decide.

He is not aware that pityriasis circinata has ever been contracted by contagion; nor has he succeeded in any of his numerous attempts to inoculate it.

The prognosis in this complaint is declared to be most favorable, thanks to the ease with which it is subdued by the mildest agencies! Our author usually relies on sulphur-baths, assisted by the previous application of tar-soap.

He has employed with success glyceroles of calomel, or of yellow precipitate, or turbeth ointment.

TRANSFERABILITY OF ALOPECIA PRÆMATURA.

The authors remark that a generally effective mode of treatment in cases of premature baldness has until very recently been among the desiderata. No doubt, when this complaint has appeared as a symptom accompanying other morbid conditions either constitutional or localized in the scalp, it has frequently been removed together with the fundamental malady. But simple, uncomplicated alopecia præmatura is probably looked upon by almost all physicians as a misfortune wholly irremediable by medical skill. It is true that various disinfecting lotions and ointments are recommended for it in the text-books, but, in view of the almost universal preference given to the neuropathic conception of the disease, it is not surprising that very little reliance has been placed upon their aid. Nor does the patient fare any better at the hands of his empirical advisers, whether voluntary or professional. Of course, no prospect of success can be reasonably held out under any mode of treatment when once the withered hair-follicles have been replaced by the growth of cicatricial subcutaneous connective tissue. But until this final stage of the malady has been reached, we should not abandon the hope of checking its advance so long as the hair continues falling out. In any case of alopecia, the affection must be regarded as still in active progress, and as consisting essentially in such falling out rather than in any primary impediment to the growth. If, after a lapse of years, hairs are still produced, albeit only to be lost, then they must have been growing at a time when the alopecia already existed. If now the contagious nature of the disease can be demonstrated by transferring it, in any individual case, to animals, in whom no stoppage of capillary growth

can possibly occur, then it follows that our efforts for its cure should be directed, 1st, to the removal of the causes which produce the loss, and, 2d, to improving the nutrition of the scalp by arousing the activity of its blood-vessels and absorbents.

The human subject in the experiments upon which these conclusions are grounded was a university student, aged twenty-five years. Himself in perfect health and of a healthy family, in which baldness had seldom occurred, he was especially free from nervous disorders, and had never suffered from headache.

He wore a full fair beard, and had a head of thin, delicate, light hair, originally abundant, soft, and elastic, but which had almost entirely fallen off over a space extending from the forehead to the lambdoidal suture, and measuring about 10.5 cm. in diameter. Only the frontal region was completely bald. The remainder of the affected surface was occupied by a scanty growth of short dry hairs, and the locks which were brought over from the sides of the head were insufficient to cover their deficiency. The hair of the bordering portions was lustreless and brittle, and could be easily removed, from six to ten hairs coming out at once when gently pulled by the fingers. The hair and scalp were also, as it were, dusted over with numerous scales of exceeding fineness, which were not annoying to the patient, and were only visible in a strong light and on close examination. The surface itself of the scalp revealed no traces of morbid action, excepting the marks of repeated scratching, which showed that slight itching was produced. These symptoms were so trifling that they had scarcely been noticed by the patient himself. It appears that he had rejoiced in a full head of hair until five or six years ago, since which time the disease had advanced almost imperceptibly.

All the hair, with the accompanying scales, which fell from this young man's head during six days could be collected from his comb and brush, *i. e.*, nearly the whole amount lost within the interval, was preserved in clean writing-paper and carefully weighed. The average weight of the daily portions was 0.298, or more than one-fourth of a gram. These hairs were then finely cut up, and thoroughly blended into a mixture with vaseline. The ointment thus prepared was applied by means of an ordinary paint-brush to the skins of a rabbit and a guinea-pig, both fully hirsute, in good condition, and with no cutaneous lesion. Each animal was well fed and cared for, and occupied a separate hutch, in a room having a uniform temperature of 15° R.

At the end of three weeks, *a decided hair-atrophy was perceptible* on the anointed parts, especially the head and back of both animals. The hairs came out at the slightest pull, remained hanging all over the walls and floors of the hutches, and the process went so far that, within a week, *portions of the hide as large as the palm of the hand became quite bald*. Besides the falling of the hair, there occurred at the same time *a very abundant furfuraceous desquamation of the epidermis*.

Thus there was evoked on the skins of these two animals the same phenomena as the scalp of the bald student exhibited, only much more speedily and in a highly intensified degree.

The experiment, however, in order to establish its crucial character, was carried still further.

A quantity of hair collected from both the creatures under observation was rubbed up with vaseline, and another rabbit and another guinea-pig anointed with the mixture. The resulting appearances were the same as before, but still more strongly marked and more rapid in their extension.

In the course of two weeks, both animals were *absolutely bald in large patches*.

Still again, from rabbit No. 2 a third was infected. *This third subject became the baldest of all.*

In the case of all the animals, it could be plainly perceived that the morbid process, starting from well-determined but accidentally located points of departure, which differed in each of them, had extended gradually, but uninterruptedly from the affected to the sound portions of the hairy integument.

Meanwhile the patient had been receiving treatment as follows:

In the first place, the scalp was vigorously shampooed for fifteen minutes every day with a strong solution of tar-soap, rinsed off by means of an irrigator with warm, followed gradually by cold water, and immediately rubbed dry with a coarse towel. A wash of sublimate solution (1.0 : 300.0 adde spirit. colon., glycerin, $\bar{a}\bar{a}$ 100.0) was next applied, the head again thoroughly dried, and a solution of naphthol (naphthol, 0.5; spirit. dilut., 70.0; aq. dest., 30.0) rubbed in. Lastly, carbol-oil, 1½ per cent, was slowly poured over the scalp, entering the cleansed and expanded orifices of its glands in such abundance that 28 G. of oil could be used at a time.

This was carried out daily for eight weeks.

For some days, as was to be expected, the hairs already loose in their root-sheaths came out faster than ever. In a fortnight, however, they ceased falling, and, after a few weeks, could only be removed by a strong pull. The itching and the scaly eruption entirely disappeared, and the treatment was followed by no unpleasant consequences whatever. Before the eight weeks were over, a new and stronger growth on the bald and partially denuded regions was unmistakably visible. At the date of the communication, three months after beginning treatment, the patient's head seemed in a fair way of recovering in full its long-lost honors.

Immediately on the conclusion of the treatment, the following test-experiment was instituted. The fallen hairs were carefully collected and weighed as before. Their quantity amounted to only 0.0058 G. per diem, *i. e.*, not quite one-tenth of a grain, or about one-fiftieth of what it was before the treatment. A rabbit was also rubbed with these hairs, but no morbid symptoms were elicited.

The authors promise to continue their investigations and duly report the results.—G. LASSAR AND RUFUS W. BISHOP, *Monatsh. f. Prakt. Derm.*, July, 1882.

THE OLEATES AND OLEO-PALMITATES IN SKIN DISEASES.

In this abstract of a paper read before the Pennsylvania State Medical Society, the author calls attention to the oleates prepared by Dr. Lawrence Wolff, of Philadelphia, as being chemical compounds of a definite and stable character—true oleates—instead of mere solutions of oxides in oleic acid, like those heretofore manufactured. They are produced by the double decomposition of sodium oleates with solutions of neutral salts. For economy's sake, the oleo-palmitates, double salts of oleic and palmitic acids with the metals or bases required, may be employed as substitutes.

In the course of his remarks, the writer deals more particularly with the oleates of mercury—zinc, lead, copper, aluminium, bismuth, iron, arsenic, and silver—showing their modes of preparation and the special advantages enjoyed

by each in the diseases to which it is applicable. Thus, the *oleate of mercury* is stated to be the best local stimulant and alterative of all the mercurials. It is employed with success in the inunction treatment of syphilis, in the chronic stage of psoriasis, and for the thorough destruction of parasites, both animal and vegetable.

Oleate of zinc is the remedy *par excellence* for excessive sweating, or in cases of hyperidrosis and osmidrosis, and is the most reliable application in that commonest variety of eczema—*eczema vesiculosum*.

Oleate of copper has effected rapid cures in cases of ringworm.

Oleate of bismuth is particularly useful pencilled over rosacea; it often subdues intractable cases of this disease: it has also been found very serviceable in sub-acute gonorrhœa and gleet, when smeared on a bougie, and thus introduced into the urethral canal for a few moments.

Oleate of iron will, no doubt, take the place of other chalybeates—particularly when the latter are not well borne by the digestive organs—and will probably constitute one of the best constitutional tonic and local astringent remedies.

Oleate of arsenic has been used satisfactorily in the ulcerating varieties of lupus and epithelioma.

Oleate of silver is a safe and efficacious remedy in erysipelas.

The superior advantages which the oleates possess over ordinary ointments are considered under the following heads:

- 1st. Their deep penetration.
- 2d. Their freedom from rancidity.
- 3d. Their cleanliness of application.
- 4th. Their great economy; they only require to be lightly smeared or applied over the surface in very small quantities.
- 5th. Their antiseptic and deodorant action.

A great drawback to the general adoption of the oleates will be the lack of knowledge that the majority of pharmaceutical chemists have, at the present time, of their manufacture. Thus, after prescribing a certain oleate, and seeing no change in his patient, Dr. S. has frequently found that either some other article or an oleic solution had been substituted for the remedy ordered. Good, honest chemists, however, if they do not understand the manufacture of the oleates, will procure them for their customers, or will go to work and make them; but their products should always be examined and seen to possess all the physical properties of true and stable oleates.—J. V. SHOEMAKER, *Med. Bulletin*, July, 1882.

ZONA.

1. Medical investigation at the commencement of the present century made us acquainted with the character, the course, and the clinical varieties of zona, but taught us nothing respecting its pathogeny.

2. Since 1865, we have known that the disease, whether developed on the limbs, the body, or the face, follows regularly along the track of the nervous filaments, whence it was inferred that the eruption probably corresponds to lesions of the latter.

3. Clinical observations and the results of pathological experiment have demonstrated that the eruption of zona is the same as that which, under like circumstances, is produced by traumatic changes in the nerves.

4. Microscopic examinations have revealed the existence of neuritis in the first place, followed by different lesions of the prevertebral ganglia and of the nervous centres.

5. We are thus brought to the conclusion that zona is a cutaneous affection

of nervous origin, and that it appears as a consequence of various lesions variously situated.—PLANCHAIS, *Thèse de Paris*, 1881.

SCARLATINA IN LYING-IN-WOMEN.

1. Scarlatina is often irregular in its evolution, and its diagnosis is extremely difficult in such cases, depending entirely upon the presence of certain proximate or remote symptoms (syndromata).

2. Lying-in females are more predisposed to scarlatina than to the other eruptive fevers; and in them it most frequently follows an abnormal type of development.

3. Puerperal scarlatinoid and the so-called scarlatiniform eruptions are in all probability only attacks of unrecognized scarlatina, running an irregular course;

4. Scarlatinal eruptions, however abnormal, should never be confounded with those of septicæmia; the latter are indicative of a serious, usually, in fact, a hopeless constitutional condition, and are analogous to the eruptions accompanying surgical septicæmia and purulent infection.

5. Scarlatina in parturient females terminates favorably in the greater number of cases, and apparently adds nothing to the dangers of their situation.—LEGENDRE, *Th. de Paris*, 1881.

ON CALCIFIED EPITHELIOMA OF THE SEBACEOUS GLANDS.

The sebaceous glands may be attacked by a species of pavement epithelioma, in which the epithelial cellules are partially or wholly calcified.

This cellular calcification is a constant feature in the disease, which it serves to distinguish from the other varieties of pavement epithelioma.

The stroma of this tissue is connective in its nature. It may be either fibrous or bony.

The ossifying process appears to constitute the final stage in the evolution of the stroma. It effects no change in the structure of the neoplasm.

Calcified epithelioma is an affection of childhood and youth, seldom appearing in adults. It is of most frequent occurrence in females.

Its character is uniformly benign, and it never relapses.

Almost all osseous tumors of the skin may properly be classed under this denomination.—CHENANTAIS, *Th. de Paris*, 1881.

THE CURABILITY OF EPITHELIAL CANCER AND KINDRED ULCERS.

Under the above title, DR. WM. A. COLLINS reports (*Cincinnati Lancet and Clinic*, July 15, 1882) the cure of several cases of malignant ulceration by means of the application of powdered ergot. He employed it in the following manner:

"The fresh ergot was freshly ground to an impalpable powder, and applied three times daily to the entire face of the ulcer with a large soft hair-pencil, the ulcer being washed thoroughly once every day. The powder was used dry, allowing all to adhere that would. After each application, the ulcer was covered with a light muslin rag wet with a lotion of

℞ Carbolic acid..... ʒ i.
Sulphurous acid..... ʒ iv.
Glycerin..... ʒ i.
Aqua..... ʒ iiss.

M. Sig. Lotio."

The patients were also put upon quinine, iron, cod-liver oil, and the other usual adjuncts to a restorative treatment.

Items.

AMERICAN DERMATOLOGICAL ASSOCIATION.—This body met at Newport, Rhode Island, August 30, 31, and September 1—Dr. J. Nevins Hyde, of Chicago, presiding.

The proceedings included the reading of the following papers:

A Case of Pigmented Neoplasm of the Skin. By Dr. W. A. Hardaway, of St. Louis.

Studies on Myxo-Angioma of the Skin. By Dr. C. Heitzmann, of New York.

Notes on Psoriasis. By Dr. R. W. Taylor, of New York.

Two Cases of Acute General Psoriasis Following Vaccination. By Dr. Geo. H. Rohé, of Baltimore.

Dermatitis Papillaris Capillitii. By Dr. J. N. Hyde, of Chicago.

Calx Sulphurata and its Uses in Cutaneous and some other Diseases. By Dr. H. G. Piffard, of New York.

The Nerves of the Skin. By Dr. A. R. Robinson, of New York.

The Question of the Contagion of Leprosy. By Dr. J. C. White, of Boston.

Remarks on the Use of Ergot in Skin Diseases. By Dr. C. Heitzmann, of New York.

The Circinate Papular Syphiloderm. By Dr. I. E. Atkinson, of Baltimore.

Several of the foregoing will appear in the columns of this JOURNAL.

The following officers were selected for the ensuing year:

President—Dr. Robert W. Taylor, of New York.

Vice-Presidents—Dr. I. E. Atkinson, of Baltimore, and Dr. A. R. Robinson, of New York.

Secretary—Dr. A. Van Harlingen, of Philadelphia.

Treasurer—Dr. Geo. H. Rohé, of Baltimore.

DERMATOLOGY SIMPLIFIED.—A century ago John Hunter divided all skin diseases into three classes: one of which is cured by mercury and the iodides, a second by sulphur, and a third class which the devil himself can't cure. Dr. L. P. Yandell, who quotes Hunter as above, is given credit for a much less complex classification than even this. He attributes all skin eruptions to malaria. Quinine is a specific for malaria—ergo, quinine is the remedy for all skin eruptions.—*Mich. Med. News.*

TREATMENT OF KELOIDAL ACNE.—1. Frictions every other day with oil of Cade.

2. Night and morning a tablespoonful of the following in a cup of barley-water:

R Iodi.....	gr. iss.
Potassii iodidi.....	gr. xv.
Tinct. conii.....	3 iiss.
Aquæ.....	3 x. M.

3. Pulverizations and alkaline douches.—BAZIN.

DR. WM. T. ALEXANDER has been appointed Associate Professor of Diseases of the Skin in the New York Post-Graduate Medical School.

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No. 2.

Original Communications.

A CLINICAL STUDY OF DERMATITIS PAPILLARIS CAPILLITII.¹

BY

JAMES NEVINS HYDE, M.D.,

Professor of Dermatology and Venereal Diseases in Rush Medical College, Chicago.

THE disease to which the name *Dermatitis Papillaris Capillitii* was given by Kaposi, has now been recognized in Germany, France, England, and America. Few cases of the malady have, however, been exhaustively studied and described, partly, no doubt, in consequence of the relative rarity of the disease, partly because of a somewhat general unfamiliarity with its distinctive features, in consequence of which even those cases which have fallen under observation have not been recorded. Perhaps it has been unfortunate in one sense, that the term *papillaris* is included in its designation, as that name has long suffered from an obscurity which has not yet been fully cleared away. Hardaway (*Papilloma Cutis*, *Arch. of Derm.*, Oct., 1880, p. 387) has well shown that the designation *papilloma* has been made to cover the lesions of lupus, syphilis, eczema, sycosis, cancer, and other equally dissimilar affections. Small wonder, then, that the word *papillaris* should share somewhat of this indefiniteness in its application. The word, nevertheless, always suggests certain general features in any lesion to which it may be applied. These features include the existence of excrescences or vegetations well projected above the general level of the surface, having a wart-like appearance,

¹ Read at the meeting of the American Dermatological Association. August 31, 1882.

and varying in color, shape, size, the dryness or moisture of the surface, and the extent to which fissures or sinuses may be recognized within the mass.

This objection aside, however, the disease to which the name dermatitis papillaris capillitii has been given by Kaposi, is one with regard to whose identity as a distinct affection little doubt can be entertained. Its limits, upon the one hand, separating it from the purely exudative affections of the scalp, and, on the other, from the malignant disorders of the same part, are now fully as defined as those of any other idiopathic affection, however uncertain may be the knowledge at present had respecting its pathology and precise nature.

The disease is described by Kaposi (*Pathologie und Therap. der Hautkrankheiten*, Wien, 1880) as characterized by the occurrence of pin-head-sized elevations, at first isolated and later confluent, which appear upon the scalp. They eventually form cicatriform plaques, on the surface of which the hairs are in some places closely associated in the form of tufts, while, in others, the appearance is that of a completely epilated surface. Such hairs as are found upon these plaques are atrophied, but when traction is made for the purpose of removing them from their follicles, they elongate, fracture, or separate with difficulty. He describes also minute pustular lesions as occurring here and there upon the surface.

The disorder commences generally at the line of union of the scalp with the nucha, whence it spreads over the occiput, to which region the author has seen the disease distinctly limited. Here papillomatous vegetations spring from the surface, usually from two to three centimetres high, secreting a liquid having a disgusting odor, which desiccates into crusts. These vegetations bleed easily beneath their crusted accumulations, and may be partially destroyed by the occurrence of abscesses within them. The growths are constituted of highly vascular papillary excrescences resembling granulations under the microscope. In the course of years, retraction takes place, and the mass is transformed into a sclerosed tissue. Extensive atrophy of the pilary follicles ensues, and there is a resulting alopecia. At other points, the hairs are bunched and tufted in the manner already described.

Kaposi adds a cut representing a vertical section of a portion of the scalp affected with this disease. It exhibits a moderate degree of hypertrophy of the epidermis, prolongation upwards of the papillæ of the corium, enormous distention and enlargement of the vessels, and beneath all, a dépôt in which the number of globular elements points decidedly to an inflammatory process.

Either the same disease or a pathological process which greatly resembles it, has been described by other authors under various names. Thus,

by Alibert, these growths or their congeners have been given the name pian ruboides and mycosis frambœsioides. Alibert, however, under these titles, describes certain vegetations which occur upon the surface of the scalp in syphilis, more particularly in women who have neglected the care of the head. One such case has been described by De Amicis under the title of Frambœsioid Condylomatous Syphiloderm of the Hairy Scalp. A translation from the Italian of his paper, made by myself, was published in the *Archives of Dermatology*, New York, 1876, p. 39, the paper being illustrated by a cut representing a vertical section of the growth. Rayer describes a similar disease as "Sycosis of the Hairy Scalp," with only incidental involvement of the hair-follicles, an idiopathic affection having no relation to the condition of follicular disease to which the term sycosis is commonly applied.

Besnier and Doyon, in their translation of Kaposi's work, furnish a note in connection with this same subject, which implies that a disease similar, if not identical, is also well known to French observers. To it they give the name papilliform and keloidean (*kéloidien*) sycosis of the nucha.

According to these authors, the disease begins by the development of papulo-pustules, exterior to, but near the hair-follicles, girt by wisps of two or more hairs. Subsequently the scalp is more deeply invaded, and then a species of involution proceeds at the surface, while a dense induration appears and persists within or below the derma. New lesions continue to appear, when the older have already proceeded to that stage where cicatriform bridges are produced. These are productive of deformity by the keloid-like projections from the surface, which are characteristic of the disorder. Several fine examples of the disease are said to be represented in the St. Louis Museum. They pronounce it to be neither common nor rare; to occur chiefly in adult years; to be remarkable for its acneiform or sycosiform lesions at the outset, followed later by irregular cicatriform or keloid-like growths; to be peculiar in consequence of its situation, and to be a disorder whose real nature is uncertain. They do not declare it to be identical with the dermatitis papillaris capillitii of Kaposi, but, to use their own language, "place it side by side" with the affection thus designated.

Still more lately, similar cases have been reported by observers present at the late meeting of the International Medical Congress, in London. Here Dr. Alfred Sangster, of London, under the title "A Papillary Tumor of the Scalp Presenting Peculiar Histological Characters," described similar lesions (*Archives of Derm.*, Jan. 8, 1882). These were rather larger than a pigeon's egg, and elevated to the extent of about half an inch from the general surface of the scalp. They were papillary in character, and, especially at the margin, of a brownish tint.

Many hairs were devoid of pigment and cropped up between the papillæ. The patient was otherwise healthy, and was said to have exhibited the tumor from his earliest recollection. It had gradually increased in size. Its deeper portions were composed of a dense fibrous tissue, while superficially there was a new growth which the author was disposed to regard as a species of sarcoma. Prof. Kaposi, who was present, pronounced this case to be an instance of the disease described by him as *dermatitis papillaris capillitii*.

In the discussion which ensued, Dr. Thin remarked that the growth was epithelial in character, and similar to that observed in rodent ulcer. According to Hillairet, the lesion was a papilloma which had probably resulted from artificial irritation. Gaskoin added that he had observed a similar case.

On the same occasion, Morant Baker exhibited a patient with a growth upon the scalp which resembled keloid, and which was covered here and there with tufts of hair. This case also was recognized by Kaposi as an example of the disease termed by him *dermatitis papillaris capillitii*.

Hardaway, of St. Louis (*l. c.*), is alone, so far as my knowledge extends, in having published a reference to the existence of the disease in this country. In a verbal communication to the writer, he describes this patient as a negro, forty years of age, with no history of syphilis or other equally serious disease in his own person or in his family, consisting of wife and children. The disorder had existed for some time, and was limited to the scalp at the back of the neck, extending thence for a short distance over the occiput. In its clinical appearances, special situation and peculiar symptoms, the disease corresponded so closely with that described by Kaposi that it was regarded as identical with the latter.

Clinical notes are appended of two cases which are presumed to belong to the same class: the first occurring in private practice, the second having been presented at my clinic at the college:

August 2, 1881. D. M., æt. 36, married seven years, by occupation a merchant, is the father of three healthy living children. His wife has never miscarried. He is of medium height, well developed, nervous, bilious temperament, and is fairly well nourished. There are no cicatrices resulting from strumous adenopathy visible about the neck. He gives no history of venereal antecedents. He states that he has suffered from no previous disease of consequence, with the exception of a mild attack of sciatica about fourteen months before examination; that his appetite is good, his digestion unimpaired, his evacuations normal, and all his functions regularly performed.

The history of his present disorder is rather indefinite. Two years ago, he first noticed what he calls "pimples" upon the hairy scalp, and

never upon any other portion of the body. These succeeded each other at irregular periods, and in the interval of their appearance, he seemed to be free from all local disturbance, with the exception of the hard lumps which they left upon the scalp surface. About three or four crops of these lesions appeared each year. They were unaccompanied by itching, but at times productive of a certain amount of pain and soreness. From these, when they were fully developed, his wife could express a small quantity of matter, followed by a discharge of blood. He states that these lesions in their several developments were always limited to an area extending from the border of the scalp at the neck to the vertex, in a width nearly corresponding to that of the occipital region.

When examined, the scalp was found to be in the following condition: In the median line, and about one inch posterior to the vertex, was a circumscribed elevation of the surface of the scalp, of considerable firmness, irregular in outline, and very nearly of the size of a pigeon's egg. No hairs covered it, the orifices of the empty pilary follicles being prominent, slightly dilated, and destitute of any signs of irritation.

There were no pustules, vesicles, scales, crusts, or other similar evidences of disease in this part. Its surface was whitish-gray in color, being nowhere reddened or hyperæmic. It was cold to the touch. Upon pressure, no fluid issued from the follicular orifices. The elevated plaque was neither tender nor painful. It was distinctly circumscribed and surrounded by an entirely healthy scalp. Around it was a vigorous growth of strong, black, and well anointed hairs.

About two inches below this point, and about one-half inch from the median line, was a tender point sufficiently elevated to be barely perceptible by the finger passed over the surface of the scalp. Upon inspection, this was found to be a slightly reddened, large pin-head-sized, distention of a single hairy follicle, from which the hair was absent. No yellowish purulent point existed at the centre. When, however, a needle was entered centrally, its withdrawal was followed by the discharge of about a quarter of a teaspoonful of a thin, gummy, mucoid fluid, evacuation of the entire quantity requiring a moderate degree of pressure of the fingers. When, this pressure being continued, no further fluid issued from the orifice of the follicle, if the fingers were removed, the depression at the point where the fluid had been evacuated became again very slowly elevated. This elevation within a brief time exceeded somewhat that which had been noticed before the introduction of the needle. Pressure upon this resulted in the expulsion of a dark-red, thin fluid, evidently made up of an admixture of the mucoid, gummy secretion already described, with venous blood. The chamber in which this was contained being a second time evacuated, was again refilled as before, and, when again pressed upon, it furnished the same contents made up in large part of thin serum mingled with venous blood. This succession of emptying and refilling of the chamber could be produced at will. Nor was the refilling of the cavity prevented by pressure with the finger. If after a single evacuation, the part were thus steadily compressed for a few minutes, gradually, after the pressure was withdrawn, the distention due to refilling of the cavity did not fail to recur. Once distended, no further appreciable change was, within a relatively brief period of time, apparent to the eye.

There were only two similar lesions upon the scalp. One of these was situated low down near the nucha posteriorly, another upon the right side of the scalp, half-way between the median line and the top of the auricle. The latter was evidently a composite, into which three follicles entered, as exploration with the needle indicated that the partition walls between them had broken down. Puncture of the nodular mass was followed by the evacuation of, first, a thin, gummatous, mucoid fluid untinged with blood, and, later, by a bloody fluid in all respects similar to that described in connection with the other lesions.

These were the sole points where a disease of the scalp could be determined; elsewhere the skin was natural, the hairs vigorous, and the surface free from pathological products of every kind.

The hairs in the vicinity of these lesions being extracted and examined under the microscope, exhibited no evidence whatever of a vegetable parasite. There was also complete absence of stumps of hairs and of filaments which had been contorted, twisted, or otherwise altered by pathological changes of structure.

From this date, August 2, 1881, till June 1, 1882, this patient was regularly under my observation. During this period, he suffered from three similar eruptive attacks, the lesions in each persisting or followed by successive crops of lesions for a period varying between two and four months. The origin and evolution of each series of lesions are well illustrated in the condition of the patient at the time when he first came under my observation. At that time, there were present upon the scalp evidences of the disorder in its several phases. In order, however, to follow with clearness the clinical history of the disease as it was here developed, the details appended are arranged as suggested by its general symptomatology.

The lesions were invariably found either quite near the vertex, or within the area posterior to this point, extending thence to the border of the hairy scalp upon the neck, and having the width of the occipital region. None were discovered at any time upon any other portion of the body, nor upon that portion of the scalp anterior to a line drawn vertically over the head from one external auditory meatus to the other. At no time were there many of these lesions simultaneously developed, the maximum rarely exceeding five or six. Of this limited number, all were rarely presented in the same grade of development at the same time. One or two secreting lesions, for example, would possibly be discovered upon the scalp, while two or possibly three might be found in the keloid-like stage of development which seemed to be characteristic of the disorder. Furthermore, there seemed to be a marked difference between these phenomena as they were displayed upon the vertex and upon other portions of the scalp. Those developed upon or near the vertex were almost certain, sooner or later, to result in the formation of keloid-like tubercles, while those occurring at a greater distance from that point not only did not undergo tubercularization to the same marked extent, but might even fail of it altogether. Again, even when such typical development occurred at a distance from the vertex, this was unquestionably much less persistent than the similar manifestations of the disease upon what may be properly called its site of election. Lastly, coalescence of several lesions was in this situation of preference also much more frequent.

The career of a single eruptive lesion may be described in detail as follows: The patient, passing his finger lightly over his scalp, would first become conscious of a point which was moderately tender. In this way, he could without difficulty detect the situations where experience had taught him his particular trouble would soon be declared. In the course of a variable time, lasting from twelve hours to two days, the finger of another passed over the surface could detect the slight elevation which has been already described. In some cases, this pin-point to pin-head sized, globoid, very rarely acuminate papule was traversed by a hair. Often the hair was entirely absent; never was it represented by a stump or distorted filament. When the hair was absent, the follicular orifice was represented by either a slightly discolored point or by the reddish-yellow roof-wall of a sub-epidermic vesico-pustule. Occasionally, the first development of the disease was by peri-pilary vesico-pustules. About this minute lesion, rarely exceeding the size of the head of a large pin, the scalp was occasionally tumid and tender, never changed in color, its follicles always filled with vigorous, unloosened hairs. When coalescence occurred, the globoid roof-wall of one individual lesion might be immediately next to a similarly involved follicle, or might be separated from it by two or three apparently unaffected hair-pouches; the latter thus interposed might or might not contain hairs.

Upon the occasions when either the finger of the patient aided by his subjective sensations, or that of the operator disclosed the existence of these follicular or peri-follicular vesico-pustules, puncture of the latter with the needle was invariably followed by the evacuation first of the thin, gummy, mucoid fluid already described. This, upon the withdrawal of the needle, flowed in certain quantity from the penetrating wound made by that instrument without the aid of pressure, but in very much larger quantity when such pressure was exerted by the fingers upon its periphery. This was especially true when the scalp about the lesion was in the tumid and tender condition described above. In all cases, however, the quantity thus evacuated was out of all proportion to the size of the lesion discernible at the surface of the scalp. The disproportion was in fact so well marked at times that it seemed natural to conclude the needle had penetrated the apex of a subcutaneous abscess, flattened between the scalp and the pericranium.

In all cases the fluid first evacuated presented the same characteristics. It was never fetid, yellowish green, blood-stained, nor did it exhibit the peculiar shade of color and the greater consistency of laudable pus. It was always thin, semi-purulent, mucoid, suggesting very clearly the similar gummatous secretion poured from the hair follicles in that variety of ringworm which is called kerion. In quantity it varied from a few drops to rather more than a tablespoonful, the larger quantity always requiring for its expulsion a moderate degree of pressure. This abundance was more noticeable in the case of lesions situated upon the vertex.

This mucoid fluid being evacuated was in each case succeeded by the discharge of a thin, serous, venous blood, or of a bloody serum. In amount this flow equalled the quantity of the gummatous fluid previously evacuated, but was at times unquestionably greater. As it welled to the surface from beneath, it invariably distended the chamber or chambers originally filled with the thin, gummy fluid and thus produced a decided elevation of the scalp. This, as has been said, could be repeatedly re-

moved, by expression of its bloody contents, but even after compression exerted for several minutes, the tumor did not fail to reappear.

This tumor may be regarded as the prototype of the keloid-like lesion which followed. At first, and for a period lasting for from twelve hours to three days, this swelling or tumor was the seat of considerable pain, very marked tenderness, and a certain degree of soreness of the rest of the scalp. Sympathetic headache occasionally came on with considerable malaise and inability of the patient to attend to his business. This, however was rather an exception to the rule, and was, when it occurred, transient in character. Generally, after the lapse of from twenty-four to forty-eight hours, the disease passed into its third and final stage, with merely a marked degree of pain and tenderness distinctly limited to the region of the swelling. The outline of the latter agreed in general with that of the subsequent keloid-like formation. It was, however, larger than the latter, was rather less distinctly circumscribed, and decidedly more elevated. It varied in size from a bean to a small hen's egg, was irregularly ovoid or even squarish in contour, rising more or less abruptly from the adjacent level of the sound scalp. At the outset it was softish to the touch, and covered with hairs apparently unaffected, exhibiting among the latter two or three follicles from which the hairs had fallen. It had also a rounded summit. Later it became smaller, denser, flattened at the summit, and cicatricial in aspect.

The final stage of this disorder was represented by the hypertrophic tubercle to which reference had been made. This resulted, I believe in every case, from a transformation of the blood-filled tumor of the scalp just described. In its typical form, this development existed near the vertex of the scalp, less frequently elsewhere, and in other situations was usually both smaller and less conspicuously characteristic. It varied in size from a small nut to small hen's egg, being decidedly flattened at the summit, well defined in outline and having either an oval, angular, or irregular outline suggesting the appearance of cicatricial keloid. Its surface was quite irregular and completely destitute of hairs, though the apertures of empty follicles could be distinctly recognized upon its surface. Its color was that of the unaltered scalp, being never in any degree hyperæmic or the seat of hyper-secretion. About it, the integument was absolutely unaltered both as to the hairs, the hair-follicles and the inter-follicular spaces. It was firm and dense to the touch, and was not productive of either pain or other subjective sensation. The length of time during which these flattened tubercles persisted was difficult of determination, for the lesions appeared often only after considerable intervals of time, which were yet sufficiently approached to permit of the coëxistence of the earliest with the latest phases of the disorder. The preference of the disease also for the vertex of the scalp often resulted in the development of the newer, either very near or exactly in the site of the older lesions. In this way it seemed quite probable that the flattened tubercle which could always be recognized upon the vertex received additions from time to time. Inasmuch as its volume did not correspondingly increase, it was rational to conclude that at some other portions of the growth, involution had proceeded *pari passu*. During all the time, however, that the patient remained under observation, a thumb-size and larger, flattened tubercle quite destitute of hairs could be seen upon or near the vertex, in connection with one or two similar and less conspic-

uous lesions in other parts of the area of the scalp described as liable to involvement by the disease.

Equally difficult was it to determine the length of time during which these portions of the scalp remained destitute of a growth of hair. For months certainly, no hairs covered these patches, which after further flattening assumed an irregular scar-like appearance, but which I believe were finally all, with the exception of the largest lesion upon the vertex, in the process of the involution of the disease, covered with a normal pilary growth. The hairs, both those remaining temporarily upon the tubercles to be cast off at a later date, and those of the scalp surrounding the lesions, examined frequently and carefully by the microscope, disclosed no evidences of the existence of a vegetable parasite. They were neither atrophied, twisted, arranged in tufts, represented by stumps, nor otherwise changed in their gross or anatomical peculiarities.

Upon the date of the last examination of this patient, there was no appreciable change in his condition, the disease apparently having persisted uninfluenced by treatment. The condition of the scalp, however, was in no respect worse than when he first came under observation, two or more fresh lesions recurring irregularly after variable periods of relative immunity from invasion.

(To be continued.)

SYPHILITIC DACTYLITIS OF ACQUIRED ORIGIN.

BY

F. R. STURGIS, M.D.,

Surgeon to Charity Hospital, Blackwell's Island, Third Venereal Division.

THE patient, whose fingers are depicted in the accompanying cut, entered Charity Hospital suffering from the early stages of secondary syphilis, *i. e.*, a papular eruption. Besides the skin lesion, he showed a swelling of the second joint of the middle and ring fingers of the left hand, which he stated had come on gradually (several weeks), and was unattended with any marked pain. Upon examination, the parts admitted of free handling without exciting pain, and there were no acute symptoms of inflammation. Upon cross-examination, he admitted that occasionally at night the fingers would ache, but this symptom was by no means well marked.

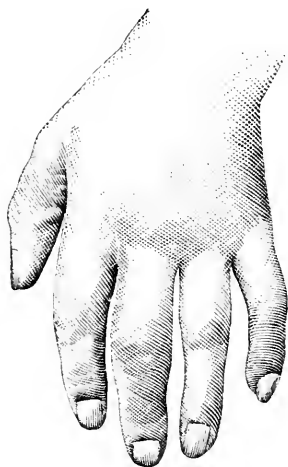
The fingers were twice as large as the corresponding fingers of the right hand, and the swelling was confined to half an inch from the joint either way. The finger could not be bent.

He was placed upon the protiodide of mercury internally, and mercurial ointment was applied locally to the joint, where, in four weeks'

time, the swelling had entirely subsided, and the motion of the finger completely restored.

This case of dactylitis is interesting in connection with its occurrence during the early stage of syphilis, while the lesion of the skin had not reached the ulcerative step, and while there were no evidences of gummous infiltration of other portions of the body. Periostitis of the shaft of the finger, as well as infiltration into the joint had occurred, akin, in some respects, to the infiltration which takes place in the later stages of syphilis, except that there was no tendency to necrosis.

Absence of pain and redness, its slow progress, and its subsidence under mercurials, serve to separate it from the rheumatic and gouty affections of these joints for which it might be mistaken when it occurs unattended with any other symptoms of syphilis.



Enchondroma of the fingers again presents features distinct from the disease under consideration. The stony hardness, the protuberances, its encroachment upon the palmar surface, and its steady progress, serve to stamp the enchondromata with features which are absent in syphilitic dactylitis.

It was specially interesting to note the decided effect produced by the treatment. Absorption of the swelling began at once, and went steadily on until all sign of the enlargement had disappeared, and the normal movements of the joints were restored, and it serves to emphasize the value of mercury in causing dispersion of the infiltrations which occur in syphilis.

16 WEST 32D STREET, NEW YORK CITY.

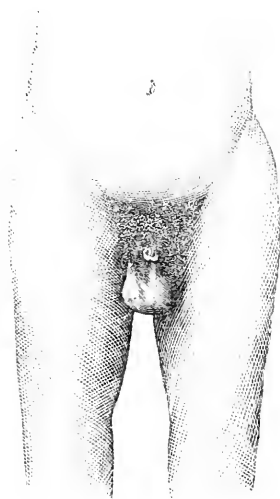
TOTAL LOSS OF PENIS FROM VENEREAL ULCERATION.

BY

P. C. REMONDINO, M.D.,

San Diego, Cal.

JOSE MONGE, a native of Sonora, Mexico, age thirty-one, in August, 1881, was living with an Indian girl, with whom he remained until October of the same year, when she left him until the end of November, at which time he slept with her one night. In the middle of December, he first noticed some sores, five in number, on the glans and prepuce, near the corona. In the course of two weeks, four of the sores healed, the fifth one refusing to close. In twenty days from the closure of the four sores, they reopened; the fifth one becoming more active, gradually ate its way through the glans, which finally dropped off. The phagedenic action going on to the body of the penis, it gradually ate its way to the pubes, and by June the whole organ had disappeared.



During all this time, Monge was in the mountains using the usual herb and root remedies peculiar to Mexican rural practice; never had a bubo, and only lately exhibited any constitutional symptoms. Previous health good. Mother still living. Father killed by Apaches. Brothers and sisters healthy.

I have seen many cases of syphilis in my practice, both in army and civil practice, but have never had occasion to witness a case of such rapid destruction from primary sores, and deem the case of considerable interest.

Society Transactions.

NEW YORK DERMATOLOGICAL SOCIETY.

129TH REGULAR MEETING, SEPT. 26, 1882.

DR. E. B. BRONSON, *President in the Chair.*

CHRY SOPHANIC AND PYROGALLIC ACIDS.

DR. P. A. MORROW formulated the following propositions:

1. That chrysophanic acid is perhaps the most efficient agent known to the profession for the external treatment of certain cases of psoriasis, especially chronic cases which have resisted other methods of treatment.

2. That its range of application is limited: in children, in patients with sensitive, irritable skins, and in acute cases generally, it is contra-indicated.

3. That in psoriasis affecting the face and hairy scalp, its intensely irritating action, producing puffiness of the face and eyelids, and its discoloring effect upon the hair render its employment impossible.

4. That it is prompt in its action—a week or ten days' active treatment being usually sufficient to develop its full therapeutic efficacy.

5. That the curative effect is only temporary: it does not afford a safeguard against relapses.

6. That it probably acts only locally and by virtue of its irritating properties, setting up a substitutive inflammation, which modifies or corrects the tendency to the inflammatory overgrowth of epidermic cells.

7. That its employment is attended with certain objectionable results, some of which always follow its use, while others seem to depend upon idiosyncrasy, physiological and morbid predispositions, etc.

8. That a brownish, prune-juice discoloration of the skin which persists long after the application is discontinued, a reddish staining of the hair and nails, and an indelible dyeing of the clothing are inseparable from its use.

9. That the erythematous and furuncular inflammations which occasionally follow its use may be classed as incidental effects, as they do not always depend upon an excessive strength of the preparation employed, but are frequently manifest after a mild application—intense dermatitis resulting in exfoliation of the epidermis in large flakes, has been observed after an application of 10 grs. to the $\frac{3}{4}$ i.

10. That the strength of the ointment recommended by Balmanno Squire ($\frac{3}{4}$ ii. to $\frac{3}{4}$ i.) is excessive: a milder strength (20 grs. to $\frac{3}{4}$ i. to $\frac{3}{4}$ i.) being usually sufficient to develop the full therapeutical virtues of the drug.

11. That in other diseases for which it has been recommended, as acne, favus, chromophytosis, eczema marginatum, etc., chrysophanic acid possesses no advantages over certain other drugs which are commonly used.

12. That pyrogallie acid is a drug which is free from some of the more objectionable features of chrysophanic acid. It does not (in 10-per-cent ointment) inflame the skin, it does not produce cedema of the face when applied to the scalp, and the discoloration is much less marked and permanent.

13. That it should nevertheless be used with caution, as pernicious results have followed its too free use. When freely used for two or three weeks, it produces an olive-green or tarry condition of the urine, with prostration, febrile disturbance, and other general symptoms.

14. That its curative action in psoriasis is much less rapid, but apparently more permanent than that of chrysophanic acid.

15. That its freedom from irritation, and its absence of odor, renders it an admirable substitute for chrysophanic acid and oil of Cade in diseases affecting the scalp and face.

16. That while its effect in psoriasis is slower and less brilliant than that of chrysophanic acid, its range of therapeutical action is much more extended. It causes to disappear the nodosities of lupus, the hyperplasias of syphilis, epidermic and papillary hypertrophies, and seems to have a good effect in promoting the cicatrization of wounds.

17. That it seems to act by virtue of its stimulant and irritating properties, it hardens and shrinks the tissues, shrivels up unhealthy granulations, and acts as a hæmostatic.

DISCUSSION.

DR. WEISSE had used chrysophanic acid a good deal in psoriasis, and had found it to answer his expectations admirably. As regards its mode of action, he had come to regard it as purely a local one. He usually ordered the scales removed from the patches by means of hot alkaline baths, and that the acid be applied twenty-four or more hours after this had been done. He thought that he obtained better results by this preliminary measure. In his early experiences with psoriasis, he had good results from the local use of creasote, but its disagreeable odor caused him to cease employing it. He regarded local applications as the most efficient means of treating psoriasis. He agreed with Dr. Morrow's conclusion that recurrences ordinarily take place after the disease has been removed by chrysophanic acid, as after other methods of treatment.

DR. SHERWELL thought that Dr. Morrow's conclusions were so just that they would be agreed to by the majority of dermatologists. He believed that ointments of chrysophanic acid, of the strength used by Squire and those who follow him, were entirely too strong. He himself never used it in a greater strength than gr. x. - $\frac{3}{4}$ i., and often prescribed seven, or even five grains to the ounce. He stated that chrysophanic acid is, as is well known, but sparingly soluble in water. Whether its active principle is so soluble or not, he did not know. But, in hospital practice, he had recently ordered the application of an ointment of gr. v. - $\frac{3}{4}$ i., and the interne, who was not familiar with its use, attempted to grind the acid up in water, triturating it freely, and then applied the supernatant liquid (which doubtless also contained a little of the pure acid in suspension) to the skin of the patient. The application excited an erythema, but it also caused the original disease to disappear in a remarkably rapid manner, much more speedily than the ointment usually does. He (Dr. S.) was so much struck by the result that he was determined to make further trial of the method. He agreed in the main with Dr. Morrow's conclusions.

DR. TAYLOR stated that Dr. Morrow's conclusions were practically identical with those that he himself had embodied in a paper read, in 1880, before the American Medical Association. He had then raised his voice against the abuse of a valuable remedy in the excessive concentration that was then recommended by Squire. Of pyrogallie acid, he would only say that his experience with it had been much less happy than with chrysophanic acid.

DR. BULKLEY desired to lay stress upon the proposition that chrysophanic acid did not prevent relapses in psoriasis, which, he thought, it was important for the Society to indorse if it saw fit to do so. He himself had, as a rule, seen relapses after cures by it. As regards the statement that it probably acts by virtue of its local irritating effects, he would call attention to the cures which had been reported to follow the internal use of the drug, either in pills or in powder, and in large doses, sometimes as high as five grains. He had made a number of

experiments of this kind himself, but was not yet prepared to state the results. The drug had, however, in some cases, seemed to exert a beneficial effect when taken internally. As regards the strength of ointment to be used, he had not found that small quantities of the drug were always sufficient, having had one patient who used it in the strength of three drachms to the ounce before the eruption would yield. He thought this justifiable in such cases, but would, nevertheless, usually begin with a strength of twenty grains to the ounce. With regard to pyrogallie acid in epithelioma, he had frequently ordered the pure acid sprinkled on the sore, which was afterwards to be covered with a poultice, and had found that its effect in cutting down the epitheliomatous granulations was often wonderful. He recalled to mind particularly one case of a large epithelioma on the temple, in which a pyrogallie-acid ointment was used without subsequent poulticing, and when he last saw the patient, the ulcer had almost entirely healed.

DR. ROBINSON agreed with almost all of Dr. Morrow's conclusions, but desired to criticise the statement that "chrysophanic acid probably acts only locally, and by virtue of its irritating properties." He did not believe that its action was due to its directly irritating effects alone, since he had not obtained his best results in those cases in which the drug excited much irritation. He had seen cases recover under its use without the production of any recognizable signs of irritation, such as hyperæmia, swelling, transudation, etc.

DR. DENSLow remarked that he had recently made trial of another drug in the treatment of psoriasis in cases with tender skins, in children, and on the face and scalp, where he regarded chrysophanic acid as contraindicated. This agent was turpentine, used at first in the strength of 1 part to 4, 1 to 3, or even equal parts with olive oil. He had applied it by friction with a cork covered with flannel (a method recommended by Dr. Piffard). In many cases, he has found this remedy to act as well as chrysophanic acid ever does, and it produces neither staining nor irritating effects.

DR. PIFFARD said that he agreed fully with sections 1, 2, 3, 5, 7, 9, 10 and 13 of the report. With regard to section 4, his experience had been different. He has often found it desirable to keep up the action of the drug for a longer period, sometimes for at least a month. He sometimes began treatment with an ointment of ten grains to the ounce, and gradually increased it to one drachm to the ounce, and as a rule, with great benefit to the patients. As regards section 6 of the report, that the drug acts by virtue of its irritating properties, he was of a different opinion. It probably does not act by these alone, but possibly has some constitutional action also. As to the discoloration produced, it did not seem to him that it lasts so long as intimated in the paper, it generally disappearing in from two to three weeks, in his experience. The color produced was, he thought, often a fine Indian (aboriginal) red, rather than brownish or that of the juice of prunes. As regards the use of the drug in chromophytosis he thought it wonderfully efficient, and in so-called eczema marginatum he thought it a valuable agent. He had never had any success with it in ring-worm of the scalp, but had often found it very useful in ring-worm of the body. The discoloration produced by pyrogallie acid he had found to be blackish or brownish. He did not use the latter drug as much as he did chrysophanic acid, having had one or two unpleasant experiences with it. With regard to section 13, he thought that it was not put with sufficient force. Pyrogallie acid is a dangerous drug when extensive applications of it are made. It has been found to kill dogs experimented upon with it. It is well known that it is absorbed by the skin, and that it is one of the most active reducers known to chemists. It is capable of deoxidizing nearly all bodies that will give up their oxygen freely, and probably exerts this action upon the blood-corpuscles when it is absorbed. With regard to section 14 he had no valuable experience to communicate, having abandoned the use of the drug (pyrogallie acid) in psoriasis and kindred diseases. In conditions characterized by epidermic proliferation he much preferred chrysophanic acid. He was aware that pyrogallie acid had been highly recommended in epithelioma and venereal ulcers. As to the staining of the clothing caused by chrysophanic acid, it seemed to him that the method introduced by Dr. G. H. Fox, of using the pure powder, and afterwards painting it over with collodion, would obviate that drawback to the use of the agent. Scarenzio used collodion in 1879 to limit the extension of the inflammation produced by the drug to the diseased patch, his method being to surround the spot to be treated with a ring of this fluid before applying the acid.

In conclusion he stated that he had encountered cases of psoriasis in which chrysophanic acid did not seem to exert the slightest effect, and he had seen other cases in which it did positive harm, causing the eruptions of fresh patches of the disease in the erythematous areolae which it excited around old patches. He had also sometimes observed that it failed to remove the disease when it had relapsed, although it had caused its disappearance in the first place.

DR. BRONSON called attention to the fact that no allusion had been made to the name of the first of the two drugs under consideration. He thought it strange that the name "chrysophanic acid" should still be used, although Liebermann had shown that it should be called "chrysarobin." He (Bronson) thought the points of Dr. Morrow's paper so well taken as to be almost axiomatic. He desired, however, to express his dissent from the view advanced that the action of chrysophanic acid is only a local one, in view of the reported instances in which the drug was applied only to limited portions of the body, and had nevertheless cured the disease in other parts. He believed that even when the scales are not previously thoroughly removed from the diseased patches, the effect of the drug is often wonderful, and he had sometimes thought that its effect upon the sound skin between the patches was of great value in hastening a cure. He described a case illustrating the unpleasant effects of the drug, that of a surgeon who, to relieve an eczema marginatum of the thighs from which he suffered, applied a strong ointment of goa powder. It seemed at first to limit the disease, but later produced an explosion of an eczematous character, which was of an exceedingly violent nature, and was evidently the effect of a toxic action of the goa powder. It proved one of the most obstinate cases that he had ever encountered.

DR. MORROW said that he always directed the scales of psoriasis to be removed before applying the acid, either mechanically or by the use of salicylic acid, one part in sixteen of alcohol. This also removed the greasiness of the skin, and seemed to help the subsequent action of the chrysophanic acid. As regards the beneficial action of the drug upon parts other than those to which it had been applied, he had found reports of only one or two cases where this was said to have happened. In one of these cases (reported by Charteris) the drug was applied to one-half of the body only, the other being wrapped in flannel. When this was removed, two or three weeks later, marked improvement was found to have taken place in the diseased patches, with which the acid had never come in contact. He believed that the results of the internal use of the drug were quite negative. He desired to emphasize the statement that certain skins will not tolerate chrysophanic acid. In one case he had found that five or even three grains of the acid to the ounce developed intense dermatitis. In another case, a young girl, even two and a half grains to the ounce was not tolerated, the whole epidermis desquamating in large flakes when an ointment of this strength was applied. He had used pyrogallie acid in lupus, and with very good results. As to the discoloration of the skin produced by this agent, it had been observed that the brownish or blackish hue was usually most marked on the palms and soles, a circumstance which was by some ascribed to the great abundance of sweat glands in these localities. He confessed himself unable to judge of the value of this explanation, but would like to see the drug tried upon the patient exhibited this evening (by Dr. Weisse) who presented the peculiarity of never sweating, and therefore presumably had but few sweat-glands.

DR. SHERWELL suggested that the deeper staining of the palms and soles might possibly be due to the greater thickness of the epidermis in these parts.

DR. TAYLOR expressed himself as being loth to theorize as a rule, but if he should form a theory, it would seem much more plausible to him to regard the action of the drug as a reflected one, through the nerves to the spinal cord, and back again upon the skin. This hypothesis would explain the action of the agent in these cases in which it produces effects upon parts to which it was not applied.

DR. PIFFARD remarked that both the theory advanced by Dr. Taylor and that which attributed the effects of the drug to absorption into the blood could be supported by analogy, but that a very striking analogy to the latter theory was furnished by the effects of mercurial inunctions, which, it was universally admitted, removed lesions in distant parts of the body by acting upon them through the blood.

In connection with the above discussion, a case of psoriasis was sent for in-

spection by DR. G. H. FOX in which one lateral half of the body had been painted with a single application of chrysophanic acid mixed with collodion. Decided amelioration of the eruption was noted on the side to which the application had been made. Dr. Fox stated that the unpainted side had also improved to a slight degree.

PRESENTATION OF CASES.

DR. ROBINSON exhibited a case of

SCLEREMA NEONATORUM.

The patient was a male child seven months old. The mother had had syphilis a number of years ago, and last year Dr. Robinson removed a spindle-cell sarcoma from one of her suprascapular regions. The child had numerous convulsions during the first twenty-four hours of its life, and on the third or fourth day intense icterus set in, which lasted several weeks. The patient has always passed only a small quantity of high-colored urine. The disease of the skin was first noticed on the second day, in the form of an induration over the buttocks, extending from the crests of the ilia down the outer aspect of the thighs to about their middle, the rest of the body remaining free from it. The child is well-nourished, and is now steadily improving. The skin is not unusually pale at the seat of the disease, is moderately oedematous, and can be slightly moved over the surface of the indurated flat mass, which has sharply defined edges, and is of very firm consistence. The skin has at no time felt cooler to the touch than the rest of the body. The disease is slowly spreading downwards, affecting first the subcutaneous tissues, and afterwards the corium, as is shown by the fact that the latter can be raised in folds over the lower portion of the mass, whereas it is but slightly movable over its upper portion.

DR. WEISSE remarked that this case of sclerema reminded him of one that he had had under treatment some years ago. The disease was more extensive in his case, having begun at the back of the neck, and extended all over the body and the backs of the legs. Baths of very hot water, with alkalies added, did great good in that case. The boy is now twelve or thirteen years old, and although enjoying comparatively good health, he is not sturdy. He could also remember a second case in which the final result was the same.

DR. PIFFARD could recall only one case under his personal observation. In the present instance, the infiltration seems to be in the subcutaneous tissues, and not in the skin. In scleroderma of adults, the cutis cannot be moved, the infiltration being in the skin itself. The prognosis in sclerema neonatorum is far better than in the former disease, except in the acute form, which generally recovers.

DR. TAYLOR had seen two cases, in both of which the disease extended over the entire body, and in both recovery was perfect. The children were two or three weeks old when he saw them. Both the skin and the subcutaneous tissues were involved, the disease presenting a thickening of the entire skin, which was immovable and showed slight redness after pressure. No treatment was employed except inunctions.

DR. ROBINSON said that the situation of the disease in this case is unusual. He stated that the best article we have on the subject is that in the second volume of "Gerhardt's Handbuch der Kinderkrankheiten." When the disease attacks the chest, there is usually interference with respiration and a slow pulse. As a rule, the bodily temperature in this disease is subnormal, but the only time it was taken in this case, it was found to be 101° in the rectum, and that at a time when there was no colitis nor dysentery, nor anything to account for the rise. This child has had acid dyspepsia and also diarrhoea. The disease attacks

the fatty portions of the skin at first, and subsequently invades the corium. In the article alluded to, it is stated that the disease ordinarily proves fatal in at most a month, but, in this case, he entertains a favorable prognosis, as the child is steadily improving.

DR. BULKLEY thought it curious that, although the disease is generally held to be a fatal one, a number of cases have been described to-night, which all recovered.

DR. WEISSE exhibited a case of

ICHTHYOSIS.

The patient was a boy ten years of age, who was born with a scaliness of the skin. Dr. W. saw him first when eighteen months old, again three years ago, and for the third time the day before this meeting. The child was at first very puny and feebly developed, presenting a dry and parched condition of the skin, with a great deal of cracking of the epidermis, causing bleeding at the flexures of the articulations. Warm baths, alkalies internally, and inunctions of sweet oil were ordered and used with benefit. Three years ago, the patient began to have trouble with his eyes, which resulted in double ectropion, with the development of opacities of the cornea, interfering with sight. The nails are improperly developed, but are improving at present. The fingers also show retarded development as compared with the rest of the hands, are drawn towards the ulnar side of the arms, and are somewhat clawed. The hair of the head is thin and sparse, and the eyebrows and lashes scattered. The teeth were slow in appearing, but the second set are coming in better. Nutrition is on the whole well performed, and the boy is of average size. The skin had been kept in fair condition by treatment. The ears are closely bound down to the head, and the edges of the auricles are thick and flattened. The entire surface is affected with the disease. The child's mother says that there is now less scaliness than there was formerly, and that she has noticed no difference in the child's condition in the summer as compared with other seasons. The child gets very red when warm, but never perspires. He suffers a great deal from cold. The mother has three other children, two younger than this one, all in perfect health. This boy is the brightest of the family, and is decidedly self-willed. The family history is free from constitutional taint.

DR. PIFFARD, in speaking of the diagnosis, said that it lay between psoriasis, eczema, pityriasis rubra, dermatitis exfoliativa, and ichthyosis. Psoriasis could be eliminated from consideration on account of the fact that the disease is universal in this case, that the skin shows but a thin layer of scales, that it is not worse about the elbows and knees, and that the trouble is a congenital one. The skin has in parts an eczematous aspect, especially about the flexor surfaces, but this may be present in mild cases of ichthyosis. The history of this case alone is sufficient to warrant us in making a diagnosis of ichthyosis.

DR. MORROW had never seen an ichthyosis so universal as this, in which the axillae, flexures and scalp are all involved. The fact that it is congenital, however, points to ichthyosis, although the circumstance that it is not more developed on the outer aspects of the extremities is peculiar. Ichthyosis always improved in summer, in his experience, which is not the case here.

DR. ROBINSON said that the red, almost eczematous appearance of the body was remarkable. As regards treatment, he alluded to one case in which the disease almost entirely disappeared under the use of linseed oil, although it afterwards returned.

DR. BULKLEY could see no reason why eczema could not co-exist with ichthyosis. He had frequently seen the two diseases in conjunction. For treatment of this case he would suggest baths, and linseed oil in and externally.

DR. TAYLOR did not look upon the case as one of ichthyosis, in which disease

the scales are more branny than here, and the flexor surfaces are less involved than the rest of the body, which is not the case here. He was inclined to regard it as a case of pityriasis rubra. There was distinct evidence of chronic inflammation of the skin, which had prevented the growth of the ears, and had caused the claw-like shape of the fingers.

DR. PIFFARD, in speaking on the subject of treatment, showed two photographs illustrating the very beneficial effects of the use of pilocarpia, and stated that Lombroso had reported a case of cure by *Ustilago Maidis*.

DR. SHERWELL said that he had seen the case for a moment only, and was then inclined to regard it as one of pityriasis rubra, but from the answers to the questions put by Dr. Piffard, and the fact that it was congenital, he now believed the disease to be ichthyosis.

Selections.

CANCROID OF THE FACE.

In general cancrroid growths are divided into three distinct classes, viz., the epithelial, the papillary, and the glandular.

A. *Epithelial cancrroid*. This makes its first appearance in the form of grayish-colored spots, covered with bran-like scales. Few persons reach a certain time of life without showing on their faces at least one of these scurfy patches, although it may be insignificant in point of size, a trifling epithelial disturbance, causing no annoyance, and perhaps never developing beyond what may be called the embryonic stage, provided it be not meddled with. These little eruptions may truly be included in the *noli me tangere* order, for the slightest unavoidable irritation causes them to inflame, crack open, tear off and ulcerate, thus constituting what is known as facial epithelioma "*en plaques*" or epithelial cancrroid.

B. *Papillary or papillomatous cancrroid*.—This second form, of which a very good example will be shown you in one of the two subjects who will soon be introduced, an old man of 60, is characterized by a peculiar condition of the dermal papillæ, in which they are elongated, heaped together, and infiltrated with epithelial matter. As the local disorder proceeds in its development, the affected surface is seen to be ruptured in some places, traversed by small furrows in others, and in others again, to be the seat of an ulcerative process, more or less extensive and profound. At some points, moreover, the papillæ merely present an acuminate aspect.

Thus you observe that this variety is very different from the preceding, from epithelial cancrroid.

In our aged patient, the papillary tumor is seated on the lower lip, and its growth is attributable to the abuse of tobacco, or rather to the inordinate use of the short pipe, vulgarly known as a "muzzle-searcher," whose tube is always hot and always in contact with the lower lip. In such cases, the tobacco produces its injurious effect, not directly, but by being contained in an instrument which, acting as a foreign body, keeps the labial papillæ in a constant state of irritation, that is, be it remembered, when the smoker is constitutionally predisposed to the complaint we are considering.

That this is one of the results of tobacco-smoking does not admit of question, and is particularly shown by the fact that papillary cancrroid of the lip is met with

in masculine subjects almost exclusively, women being absolutely exempt from the affection, except where they have taken to pipes or cigarettes like men, as is the case in certain parts of Brittany. And in these districts, papilloma of the lip occurs as frequently in one sex as in the other. Moreover, we know that the disease was very rarely observed before the introduction of tobacco.

C. Glandular canceroid. The female patient now before you presents an example of the third or glandular variety of canceroid. This affection was first described by M. Verneuil. It may affect the hair follicles, the sebaceous or the sudoriparous glands.

The disorder is anatomically characterized by the formation of small granulations, closely aggregated, and having the appearance of little pearls, covered by the epidermis, and resting on a more or less indurated base. The epidermis itself is sometimes involved; it may ulcerate and discharge.

As to the comparative frequency of their occurrence, the papillomatous canceroid stands first among the forms described, next comes the epithelial, while the glandular variety is more seldom met with than either of the others.

In the present case, the operation to be performed is one of unusual delicacy, owing to the fact that the canceroid, as you perceive, is seated on the lower eyelid. The loss of substance involved in its removal by the simple process of ablation would necessarily give rise to a cicatricial ectropion, a state of things not only extremely disagreeable, but most unfortunate in its results upon the eyeball itself. In the first place, there would be constant lachrymation; next, the lid would be drawn downward, so as to leave uncovered a large portion of the cornea; ulceration of the latter would speedily ensue, and vision on that side inevitably be destroyed.

In order to avoid these consequences, we shall have recourse to a more complicated procedure. A triple incision will be made in the form of a triangle, whose base will be directed upward, and carried along the free border of the lid, while its vertex will point in the direction of the cheek. The sides of this triangle will include the entire glandular tumor. It will then be possible to bring together the edges of the wound, from vertex to base, so that the lid, instead of being drawn downward, and thus giving rise to a cicatricial ectropion, will be carried upward, and will tend rather to lessen the size of the palpebral orifice. —*Clinical lecture by M. RICHET at the Hôtel Dieu (Gaz. des Hôp., May 23, 1882).*

THE TREATMENT OF SYPHILIS WITHOUT MERCURY.

DR. J. EDMUND GUENTZ, in a recent monograph,¹ says that the bichromate of potash was first recommended for syphilis many years ago, but, owing to certain disadvantages attending its internal administration, has hitherto been entirely neglected by the profession at large. It is a substance which can only be exhibited in very small doses, as it readily provokes violent vomiting, cardialgia, acute gastric catarrh, and even gastritis. Such doses are so slow in their operation that the medicine is without real value when a prompt removal of syphilitic symptoms is demanded, or when it is absolutely necessary to attack the disease energetically with a view to its speedy eradication. But in cases where such active measures are not called for, prompt and quickly-operating agents (such as mercury, in particular) are found to offer no security for a complete and permanent cure. Hence, our author was led to test the virtues of the bichromate of potash on patients who had been ineffectually treated by other physicians in the ordinary way, with results which, as he describes them, must be considered remarkably encouraging.

¹ Die Syphilis, Behandlung ohne Quecksilber, Berlin, 1882.

For the purpose indicated, the bichromate is not available in solution, as, even when considerably diluted, it easily gives rise to vomiting. Given in the form of pills, this irritating effect is much less marked; but it is then quite easily decomposed, a "chromoxydul" being produced which is insoluble in the stomach, so that only a small portion of the bichromate passes unchanged into the circulation, and exerts its curative influence. This may be obviated by freshly preparing the pills every night and morning, as they are required; but under ordinary circumstances, such a precaution is, of course, impracticable. In order to prevent this ready decomposition, Dr. G. has been in the habit of combining the bichromate with an equal quantity of the nitrate of potash, as in the following formula:

℞ Potassii bichromat.,

Potassii nitrat. āā gr. xv.

Micæ panis gr. xc.

Misce ft. pil. No. cc.

Sig. One pill to be taken three times a day, after meals.

The author, however claims to have discovered a better way of using this remedy, viz., by combining it with a carbonated mineral water, the latter being so prepared, and the quantity of the main ingredient so proportioned, as to obviate all risks of injurious secondary effects.

The author declares that the results, in all forms of syphilis, were so surprising (he might even say brilliant) that, *for many years past*, during which he has prescribed the "chromwasser" for over one thousand patients, *he has found mercury entirely unnecessary in his treatment of this disease.*

In support of these assertions, elaborate tabular statements are presented, containing an analysis of 85 cases, which were sifted from a total of 194 cases of primary syphilis treated in the course of a year and a quarter, by a process intended to exclude every source of error that could possibly be detected. These 85 cases are divided into two classes: the first, containing 71 cases, including those in which the sores were *not* cauterized and no treatment whatever was employed except the author's "chromwasser;" the second, 14 cases, comprising those in which the sores *were* cauterized during the time of administering the medicine.

The following is the general summary of results in both the classes:

71 *not* cauterized, of which 47 remained free from secondary symptoms, and 24 developed them.

14 *cauterized*, of which 12 remained free from secondary symptoms, and 2 developed them.

Total, 85 patients, of whom 59 escaped secondary symptoms, and 26 were affected by them.

Or, according to the strictest computation, every case in the least degree doubtful being thrown out:

Not cauterized, 37 exempt from secondary syphilis.

Cauterized, 12 exempt from secondary syphilis.

That is, 49 out of the 85 remained undoubtedly and absolutely free from any further manifestation of the disease.

ON SUPERFICIAL EXCORIATIONS OF THE TONGUE.

This subject has hitherto received but little attention, and its history may be very briefly summed up. Caspary and Unna, in Germany, and Parrot, in France, were the first to describe it in detail, referring altogether to some fifty cases, which shows the comparative frequency of this long-neglected affection. The

German observers deny its origin in syphilis, although in several of their cases it coexisted with the latter: the French, on the other hand, who studied it only in foundling hospitals, recognize it with equal certainty as the product of an hereditary taint. Hack supports his own positions by a minute account of several cases occurring among members of two families in his private practice, in both of which he was enabled to trace the desquamative processes on the tongue *through three generations*.

The characteristic appearances presented by the organ in one of these instances (that of a married female), are described as follows :

What is called by Unna a "deficiency of papillæ in streaks" had resulted in the formation of a slight longitudinal furrow, and in a tolerably symmetrical fissuring of the edges of the tongue. On the summit of the dorsum of the latter were several circular, shallow excoriations, which were distinguished from the gray-coated surface surrounding them, only by their flat and sunken bases, not by any difference in the color of their borders. The margin and tip of the tongue, on the other hand, showed a series of oblong and oval sunken spots bordered with yellow, and sharply marked off—inwardly, more particularly, by the difference in elevation, while in the direction of the healthy mucous membrane no such difference existed. These sunken, yellow-bordered places were of deep-red and studded with prominently-projecting papillæ. They were also continuous on the under surface of the tongue, save that here their edges took on a grayish-white color. The subjective symptoms were a violent burning sensation from the contact of acids, and some difficulty in moving the tongue.

In the case of another woman (also married) the excoriations were found only on the under surface of the tongue. On the upper surface the following anomalies presented: No fur (*Zungenbelag*) was to be seen. The red-tipped fungiform papillæ stood prominently out from a smooth whitish base—the whole appearance being such as to impress one with the idea that *the filiform papillæ of the tongue were almost undeveloped*.

Both of these women were anemic, and both labored under a functional disorder of one of the chordæ vocales, rendering the voice a falsetto from any slight excitement.

In both, moreover, the disease of the tongue had existed from childhood, and the father of one patient and the mother of the other were found on examination to be similarly affected, though to a comparatively trifling extent. Several grandchildren displayed the same condition.

The following are the conclusions which H. considers himself entitled to draw from his double series of observations :

Hereditary syphilis may undoubtedly be excluded as having any causal connection with the above-described phenomena.

As to their hereditary nature in general, the liability to such exfoliative processes on the tongue must be regarded as possibly, not necessarily transmissible.

Whether they occur innately, or are first developed after birth, is left still an open question. The cases just cited certainly go to prove that neither difficult dentition nor acquired syphilis are necessary to their production.

It is mentioned as not an unimportant fact that, like Gubler, Hack has observed only a continuous advance of the yellow-bordered excoriations, instead of their change of place by leaps, as reported by Unna and Caspary.

He also thinks it singular that this particular sort of sores on the tongue were observed by him in females only, and remarks that, on examining the tongues of 600 soldiers in garrison near his residence, he found among them but twelve cases

of excoriations of an atypic character, and not one of the characteristic yellow-bordered variety.

Therapeutically, he has tried, among others, the means recommended by Unna in this affection, without any result worth speaking of.—HACK, *Monatsh. f. prak. Derm.*, April, 1882.

ACUTE CIRCUMSCRIBED CUTANEOUS ŒDEMA.

Of the disease thus denominated only a few cases have been hitherto described, although it does not appear to be of very rare occurrence. It is characterized by an œdematous tumefaction of the skin and subjacent cellular tissue, in circumscribed spots measuring from two to ten centimeters in diameter. These are found most frequently on the extremities, especially in the vicinity of the joints, also on the body and face, particularly the lips and eyelids. The swollen portions merge gradually into the surrounding integument, which they resemble in color, or they may be quite pale and translucent—less frequently of a reddish hue. A feeling of tension is usually complained of in these places, but there is seldom any itching. Portions of the mucous membranes may at the same time be similarly affected—as, for instance, the lips, velum palati, pharynx, and entrance of the larynx may be so swollen as to occasion considerable apnoea. From the symptoms which appeared paroxysmally in one case it may be inferred that the gastro-intestinal mucous membrane is also liable to be attacked by this disease. In another instance repeated serous effusion into the joints took place.

The tumefactions make their appearance suddenly, usually in several localities at once, reach their height in one or more hours, and then as suddenly disappear, after lasting from several hours to a day. While one set of swellings is going through this process, others may arise in places remote from them, and in this way the complaint may be protracted for several days or even weeks.

As a rule, there is no marked constitutional disturbance, though in some cases, besides the precursory indisposition, a general feeling of illness was complained of during the period of eruption, with slight dulness of the head, thirst and diminished secretion of urine. The bodily temperature has not been observed.

When the disease attacks an individual more than once, it assumes a milder form, and generally selects the same localities as at the first invasion. Such recurrences take place, sometimes at varying intervals, sometimes every week, with almost typical regularity, throughout a series of years.

As exciting causes may be mentioned sudden refrigeration of the skin, catching cold, and excessive bodily exertion.

Acute œdema of the skin appears to occur more frequently in men than in women. In the cases reported, the subjects were generally healthy; some were of an excitable nervous organization. By one patient, who had been attacked at pretty regular intervals, the complaint was transmitted to his son, in whom it was manifested before he was a year old.

Externally, the disease under consideration bears a certain resemblance to *erythema multiforme*, as also to *urticaria*; and forms of transition between the first and the two last-named maladies have likewise been observed.

Pure cases of cutaneous œdema, however, may readily be distinguished by the slight degree of redness, and the stronger swellings they present, the latter extending to the subcutaneous cellular tissue; by the varying localities attacked, and usually by the absence of itching. In its tendency to spread by leaps, the affection is directly opposed to *erythema multiforme*, and equally so to *erysipelas*.

by the latter characteristic, as well as by the short duration of its eruption, and the absence of well-marked febrile phenomena.

As analogues of acute circumscribed cutaneous oedema, our author makes mention of menstrual oedema, the intermittent oedema following malarial fevers, and the so-called typical articular swellings.

With respect to treatment, since this ailment is chiefly troublesome by reason of its frequent recurrence, a careful regimen, especially in regard to diet, will often prove serviceable in the direction of prophylaxis. The attacks may sometimes be shortened by rest, foot-baths, and derivation to the bowels. Good results have been obtained from the administration of atropine. Oedema of the larynx sometimes renders scarification necessary.—QUINCKE, *Monatsh. f. prak. Derm.*, July, 1882.

THE CURE OF LICHEN RUBER WITHOUT ARSENIC.

To Ferdinand v. Hebra belongs the credit of having introduced the use of arsenic in the treatment of Lichen ruber, and it is owing to his influence that this method has become almost stereotyped in Germany. In this disease, more than any other, our physicians are accustomed to regard external means as merely palliative, as unimportant adjuncts to the internal administration of arsenic. Such, if published reports are to be trusted, is certainly not the case in England or America, and, in fact, outside of this country the position I am about to take would hardly give rise to a misgiving among members of the profession.

I have now arrived at the conviction, founded on my last year's experience, that *lichen ruber exudativus* is a complaint curable by purely external measures, when these are energetically employed. Out of thirteen cases of L. ruber which I treated in private practice and in my clinic during the above period, six were completely cured in from eight days to three weeks by means of the following:

Ung. zinci benzoati.500 0 gm.
Acidi carbolici20.0 gm.
Hydrarg. bichlor. corr.0.5-1.0 gm.

This was freely rubbed in over the entire surface night and morning, the patients remaining all the time in bed under blankets.

As a vehicle, I have used other ingredients in place of the zinc-ointment, but it is absolutely essential that, whatever may be the basis of the prescription, it should be opposed in its operation to the eczema-producing properties of the carbolic acid and the sublimate.

The treatment, in all the cases, was exceedingly well borne. Stomatitis was warded off by keeping the mouth well washed out with chlorate of potash, lotions of sulphur, etc. Carbolic urine appeared on the second day of the treatment, and slight transient weakness on the fourth, but these trifling effects were hardly noticed by the patients, so rapidly did improvement set in, and so great was the relief experienced from the cessation of the itching, and from the consequent ability to sleep.

In every instance, a close relation was observed between the length of the treatment and the duration of the ailment previous to commencing it.

I maintain, therefore, that the condition upon which the speedy cure of lichen ruber principally depends, is that the application of the carbolic acid and sublimate be commenced as early as possible.

Arsenical treatment, however, whether internal or by injection, is not abso-

lutely contra-indicated by the measures I have just described. On the contrary (as experience has taught me, since the six cases above referred to), it may sometimes be judiciously united with the latter from the beginning.

I recommend this treatment:

1. In all difficult cases of *lichen ruber (acuminatus)* accompanied by intense itching and rapid failure of strength, as the best, giving immediate relief, and speedily resulting in a cure.

2. In milder forms of the complaint, it may be resorted to in the night-time only, the patients going about their business as usually during the day.

3. In very inveterate chronic cases, where the eruption is quite circumscribed, I advise the application of a plaster of mercury and carbolic acid as a suitable modification of the more energetic procedure already detailed.—P. G. UNNA, *Monatsh. f. prakt. Dermatol.*, March, 1882.

CASE OF TUBERCULAR LEPROSY ORIGINATING IN CONTAGION.

This is the title of a paper read by DR. I. E. ATKINSON at the fifth annual meeting of the American Dermatological Association, and reported in the *Archives of Medicine*, June, 1882. The history it contains is reported at length, not because any unusual or striking features became manifest, but in order to make it clear that the author "had to do with a perfectly well-marked case of tubercular leprosy, in view of the very important etiological aspects of the case." The patient, a married woman 40 years of age, applied for relief at the University Hospital Dispensary, October 18, 1880. She was of German parentage, but had herself never been outside the limits of the State of Maryland. Had had nine children, five of whom were still living, and appeared to be perfectly healthy. Her husband was a healthy laborer, with no evidence of disease. Cutaneous disorder first appeared in May, 1878. The case, since then, had been slowly progressive.

With regard to the origin of the disease in this instance, Dr. A. refers it without hesitation to the woman having become acquainted with a man named Brown, who had lived in the same street with her (in Baltimore) for two years, during half of which period he was her next-door neighbor. This Brown was the same individual whose case was reported as one of tubercular leprosy in the *Maryland Med. Jour.* for July, 1878, by Dr. George H. Rohé. The families became intimate, but, according to the woman's statement, she never had anything to do with Brown, never even shook hands with him. At this time he had eruptions and nodules on his face, and was in bad health.

Leprosy, it appears, is a disease of the very rarest occurrence in Baltimore and Maryland, and Dr. Atkinson's is the only case reported as having certainly originated within the limits of the State. He considers it "in the highest degree improbable that it should have developed a few years after having been next-door neighbor to one of the only three lepers that have been observed in the city of 400,000 inhabitants in a period of many years, without having in some manner derived it from him."

With a view to the detection, if possible, of the so-called "bacillus lepræ," the entire lobe of the patient's right ear was removed with scissors, and submitted for histological examination to Dr. I. Bermann, who reports that he "finally got a glimpse" of the object sought for.

The author remarks in conclusion that he "cannot close this paper without referring to the national importance of settling this question of the etiology of leprosy. In no country of the world is definite information upon this subject

so urgently demanded as in ours. With Chinese lepers pouring in upon our Pacific coast, with Norwegian lepers settling in the Northwest, with an increasing number of lepers in the State of Louisiana, we seem to be threatened at many points. Should the disease prove to be contagious, as from an unprejudiced consideration of my own patient I am convinced it is, there can be no subject more worthy of the earnest consideration of our sanitarians and legislators."

[The man Brown referred to above, later became an inmate of the Charity Hospital, New York, where he subsequently died in the service of Dr. Piffard. Another case of leprosy, in whom the first manifestations of the disease occurred while a resident of Baltimore, has, during the past year, been in the same hospital and service. In this patient, however, it is probable that the disease was contracted during a previous residence in the Bermudas.—Eds.]

INTERNAL USE OF CHRYSOPHANIC ACID IN PSORIASIS.

Although chrysophanic acid applied externally is undoubtedly our most successful agent in the treatment of psoriasis, yet this mode of using it has many drawbacks. It is excessively dirty; to a delicate skin, the acid proves extremely irritating; it stains the hands and the integument generally of a dingy greenish-brown color; it changes light hair to an undesirable hue; it soils underclothing, linen, etc., the stains it produces being with difficulty removable; and, lastly, the quantity of the drug needed to effect a cure is very considerable, and the cost of it places it beyond the reach of the poor. In view of these disadvantages, Dr. Alexander Napier, of Glasgow, about a year ago, was led to administer the remedy internally, with results which he describes in an article in the *Lancet* for May 20, 1882.

Three cases of typical psoriasis are given in detail. The first of these was perfectly well on leaving off treatment—a slight, unnatural paleness of the skin on the site of some of the patches being the only remaining trace of the eruption; the other two were much improved when last seen. Of several other cases treated in the same way, no satisfactory report could be given, owing to the irregularity of attendance and carelessness in following instructions so characteristic of the bulk of dispensary patients.

This experience, the author considers, is sufficient to show that in certain cases psoriasis may be cured by the internal use of chrysophanic acid, that the belief that the remedy has a general as well as a local action on the system is well-founded, and that the drug is capable of being absorbed when taken in this way, and of exercising a special influence on the skin after absorption. This action may possibly be found to be due, as in the case of arsenic, to some special elective influence of the drug on the epidermis. Treatment by chrysophanic acid used in this fashion appears somewhat slow, yet there must be many cases in which this mode of treatment will prove the best; as, for instance, when the eruption is very extensive, when the skin is very delicate and irritable, and when expense is an obstacle to the use of the drug in any other way. It seems that the dose should at first be small. Half a grain is suggested as a good medium dose for an adult to start with. The dose should be increased gradually as the stomach is found able to bear it. It would appear, however, that if once intolerance of the drug be set up, doses which were previously well borne cause vomiting and other signs of gastro-intestinal irritation, and small doses must again be resorted to. The drug seems also to be better sustained when given in powder, after food, and combined simply with sugar of milk.

The paper concludes with an account of a case in the Glasgow Royal Infirmary of a girl thirteen years old, under treatment by Prof. Charteris, in whom the eruption was very extensively distributed, no region of the body being free from it. One-half grain of chrysophanic acid was administered three times a day, the dose being gradually increased until the patient took nine separate doses daily of one grain each. At first, there was slight sickness of the stomach, but complete toleration of the medicine was soon established. The influence of the remedy on the eruption was most strikingly manifest after about six weeks' treatment: most of the patches on the trunk had quite disappeared, while those on the limbs were healing very rapidly, especially in the centre.

ON BENIGN AND MALIGNANT SKIN-AFFECTIONS.

From the stand-point taken in this lecture, all cutaneous diseases may be divided into three great classes, viz., those which are always mild, those which are always malignant: and those which are of a mixed character, being sometimes mild and sometimes malignant. To the first class belong all affections (with the exception of eczema) whose primary lesion is a vesicle—as hydroa, miliaria, herpes, varicella: also two diseases which commence with a papular eruption—lichen and strophulus: one squamous malady, pityriasis: several complaints characterized by sanguineous discolorations, like erythema and roseola: and all those which exhibit pigmentary stains, such as lentigo, chloasma, hepatic spots. None of these is of any serious consequence, either locally or constitutionally considered.

In the second class, that of diseases uniformly malignant, are placed exfoliative herpes, rupia, and the inveterate form of chronic pemphigus. These, by their destructive action on the entire integument, entail the most formidable complications, and frequently result in death.

The third class, consisting of disorders which are sometimes mild and sometimes malignant, includes three diseases to which, on account of their frequency, especial attention is directed. These three are eczema, psoriasis, and prurigo.

Eczema, it is pointed out, may in general be properly classed among benign affections, but, under certain conditions, it assumes a very different character, and may fairly be denominated malignant. These conditions are, 1st, when it is seated in the face: 2d, when it invades the lower extremities: 3d, when it is acute, confluent, and covers very large surfaces at once—in other words, when it is no longer a local but a general malady.

A vivid picture is presented of its ravages under such circumstances.

Psoriasis, in its two widely-differing forms, *simplex* and *inveterata*, is similarly described, and exhibited as possessing, under the latter aspect, every attribute of malignancy.

Parallel considerations are applicable to *prurigo*. This complaint, when meriting the name *Prurigo mitis*, or when *parasitical* in its origin, is of short duration, easily cured, and results in no serious derangement of the general health. But a very different state of things is produced when it takes the shape of *prurigo feror*, or *prurigo formicans*. More intolerable sufferings than those to which it then gives rise can hardly be imagined, and the vital forces inevitably fall under their continuance. When thus characterized, it should undoubtedly be regarded as malignant.

Examples might be multiplied, but those mentioned are sufficient, the author thinks, to establish the correctness of the three main divisions upon which he insists.—GUBOUT, *Gaz. des Hôp.*, May 30, 1882.

TREATMENT OF CUTANEOUS DISEASES BY SCARIFICATIONS.

After diligent study of almost all the cutaneous maladies in which linear scarifications have been resorted to, and after comparing the results obtained from this method with those which have followed the employment of other medical or surgical means—availing myself, moreover, not only of the opinions expressed by the most competent authorities, but also of my own observations in numerous cases—I have arrived at the conviction that in the treatment of many skin diseases, the above-named procedure must be regarded as more prompt and satisfactory in its consequences than any other previously employed.

A rapid improvement and speedy cure, without liability to a return of the disease; white, thin, and smooth cicatrices—such are the advantages offered by this mode of treatment.

In no form of disease, however, are those advantages at once so strikingly apparent and of such capital importance as in the most dangerous, most destructive, and most disfiguring affection of its class—*lupus vorax*.

Not unfrequently, three or four scarifications are sufficient to arrest the progress of the complaint, and after a few months of treatment the cure is complete, the resulting cicatrices being productive of much less deformity than those left in similar cases after any other process.

I am aware that even this method is not without its disagreeable features. The pain it occasions is sometimes quite severe, a troublesome amount of hemorrhage may be produced, and the treatment, now and then, is necessarily protracted, involving a frequent repetition of the process. Yet its incontestable advantages, in the cases to which it is applicable, are so predominant and so far outweigh those derived from any other source, that linear scarifications must take the highest rank among the means of combating many cutaneous disorders, especially those hitherto most difficult of cure.—V. BARTOSZEWICZ, *Th. de Paris*, 1882.

CERTAIN DISEASES OF THE SKIN, AND THEIR TREATMENT BY LINEAR SCARIFICATIONS.

1. Linear scarifications constitute the best mode of treatment in tubercular lupus.

They are to be preferred to scraping, either alone or in conjunction with the former.

In erythematous lupus, scarifications act with less promptitude, and in acneic lupus they are ineffectual unless carried deeply and combined with punctures.

2. Together with this means, internal medication should always be employed.

3. Scarifications are seldom useful in the treatment of vascular naevi; yet it is well to give them a trial in such cases by operating on a small portion of the tumor.

4. They are more serviceable, when combined with epilation, in parasitic sycosis, with abscess of the derma, as also in non-parasitic sycosis (*impetigo sycoformis*).

5. Greasy seborrhoea, so refractory under other treatment, is amenable to this.

6. In rosacea, scarifications can only be relied on before the hypertrophy has become too far advanced.

7. Notwithstanding apparent counter-indications, this practice has been successfully employed in some cases of keloid.

8. Scarifications probably act in several different ways—by substitution or revulsion, and also by obliterating a certain number of blood-vessels, so as to prolong the life of the healthy tissues, while those already becoming devitalized are disposed of by cutting off, even though but partially, their sources of supply.—AUBE. *Th. de Paris*, 1881.

CONTAGIOUS ACNE INDURATA, ORIGINATING IN VARIOLIFORM OR VARIOLOID ACNE.

The contagious nature of varioliform acne has been demonstrated by MM Caillaux and Hardy, and is attributed by the latter, with much probability, to the presence of a mycoderm which he has detected in the pustules of the disease. The object of Mr. Brame's paper is to show that *acne indurata*, at least when derived from the above-named form of the complaint, is contagious likewise.

Several cases are adduced in support of this proposition, and the author's general conclusions are formulated as follows:

1. Not only is varioliform or varioloïd acne contagious, but it generates an *acne indurata* which can both be reproduced by inoculation on the original patient, and communicated to others.

2. *Acne indurata* may perhaps also be regarded as contagious in its own nature, owing to the presence of a mycoderm which I have denominated *acne incurvata*.

3. Varioliform acne should always be treated by puncturing the pustules, which may then be painted with freshly-prepared iodide of silver. If there are ulcers, a cerate containing coal-tar, glycerin, or chalk should be previously applied.

4. The treatment of *acne indurata*, whether contagious or not, should likewise consist in repeatedly puncturing each pustule and afterwards applying the iodide of silver, followed, when the pustules have begun to desiccate, by a wash of iodide of tannin in first-proof alcohol. Should the latter produce a slight inflammation, we may return to the iodide of silver.—BRAME. *Gazette des Hôpitaux*, Aug. 17, '82.

TREATMENT OF RINGWORM OF THE SCALP.

Dr. Tom Robinson¹ writes as follows concerning the treatment of this usually very intractable affection:

"In ringworm of the scalp, I always refuse to treat the case unless the child has the head shaved, believing it to be impossible to bring any remedy into contact with the fungus unless this be done. I then direct the scalp to be well washed with a liquid made by dissolving one drachm of the Pharmacopœia soft soap and half a drachm of carbonate of potash in twelve ounces of orange-flower water. After this is done, I direct my patient to wear a piece of lint covered with oil-skin continually for a week, which lint is saturated every two hours with the following solution:

Hydrarg. bichloridi.....	gr. vi.
Acidi carbolic.....	℥ i.
Sp. vini rect.....	℥ vi.
Glycerini.....	℥ vi.
Aquæ.....	ad ℥ xi.

Misce.

¹ The Etiology, Pathology, and Treatment of Baldness and Grayness. London, 1882.

"After this has been earnestly carried out, I am sure the disease will in but few instances give further trouble. The rings will probably be scaly for some time afterward; but if the head is kept clean and the nitric oxide of mercury ointment of the Pharmacopœia used at intervals, the normal appearance will be resumed."

USE OF PYROGALLIC ACID IN THE TREATMENT OF VENEREAL ULCERS.

The leading advantages possessed by pyrogallie acid in the treatment of Chancres, consists in the promptitude and certainty of its action, which involves no danger of injury to surrounding parts, and in its complete destruction of the virus.

Slightly caustic, and at the same time astringent in its properties, it is superior to nitrate of silver on account of the profound alteration it effects in the substance of the sore, and to other similar agents, in that it may be applied at any period, whatever may be the age or malignity of the lesion.

The specificity (if we may use the term), as well as the greater celerity of its action on the poison of the disease, render it preferable to iodoform, whose penetrating and disagreeable odor both annoys the patient, and betrays the nature of his malady.

Iodoform, it is true, exerts an anæsthetic influence which is sometimes very desirable, but this is not, in every instance, to be relied on, while the pain produced by pyrogallie acid is not severe enough to constitute an obstacle to its use, and, moreover, can always be allayed by such means as the application of chloral compresses, or the subcutaneous injection of morphia.

The only precaution to be observed in the employment of the acid, is not to combine it with soap or any other alkaline substance, as by these we know that it is readily decomposed.—ANDRIEU, *Th. de Paris*, 1881.

TREATMENT OF SOFT CHANCRES AND OF BUBOES BY SALICYLIC ACID.

1. The efficacy of salicylic acid in the treatment of soft chancres and of buboes appears to us to be unquestionable. While not an absolute specific, it is, in our opinion, capable of being most advantageously employed.

2. Odorless, only slightly painful in its application, soluble in alcohol and in glycerin, and leaving no stain on linen, it is preferable, in these important respects, to most other agents employed for the cure of the above-named affections, while perhaps inferior in certain other particulars to some among its rivals.

3. It may be resorted to in all cases, both when the sores are large and well-exposed, and when they are sloughing extensively, or are reached with difficulty; and it is equally available in private and in hospital practice.—AUTIER, *Th. de Paris*, 1881.

CLINICAL AND EXPERIMENTAL INQUIRIES INTO THE PATHOGENY OF ERYSIPELAS.

1st. Erysipelas originates in a living material principle, foreign to the human economy, but capable of reproducing itself within the same.

2d. This principle is a *spherical bacterium (bacterium punctum)* which may be either solitary or grouped in chaplets, but is *always devoid of motion*.

3d. Such *immobility* is apparently a pathognomonic attribute of the erysipelatous microbe.

4th. This bacterium, *so far as ascertained*, is the only organism which can produce erysipelas.

5th. It is not developed in all subjects: certain soils being more favorable to its growth than others.

6th. We are justified in assuming that erysipelas never occurs spontaneously: the germ of the disease must be introduced into the system through some external lesion.

7th. When erysipelas is *artificially* produced in animals, it is due, not to the experimental operation, but solely and entirely to the specific bacteria.

8th. When the serum of an erysipelatous vesicle is deprived of its bacteria, it becomes incapable of giving rise to the characteristic eruption.—DUPEYRAT, *Th. de Paris*, 1881.

ETIOLOGY AND PATHOGENY OF ELEPHANTIASIS ARABUM.

1. Elephantiasis originates in a disordered state of the circulation, which results in an acute or chronic organized œdema. It is characterized by hypertrophy of the cutaneous tissue, which may be accompanied or not by an inflammatory process.

2. It is connected with numerous predisposing causes. Any mechanical impediment to the venous or lymphatic circulation may favor its production—such as varices, ganglionic affections, obstructed lymphatics, etc.

3. All influences capable of producing erysipelas of the limbs or genitals (repeated irritation, excessive humidity, etc.) may act in the same direction.

4. There is no ground for regarding elephantiasis as a contagious malady, yet in view of the latest scientific deductions, we may admit the agency of a parasitic organism in its development, by irritating and obstructing the lymphatic system, so as to give rise to erysipelas. Syphilis, in virtue of its profound effects on the constitution at large, and especially on the lymphatic system, must be ranked among the predisposing causes.—CLARAC, *Th. de Paris*, 1881.

Correspondence.

A CURIOUS CASE.

To the Editors of Journal of Cutaneous and Venereal Diseases.

GENTLEMEN:—During the summer of 1876, a gentleman—an artist—came to me for treatment for a skin disease which was causing him great annoyance. On examination I found the skin to be rough but not broken, except where torn by the finger nails in scratching. The patient was fearful that the disease might be contagious and warned me not to touch him or even his clothes. I made him a prescription for which he paid me with money taken from his vest pocket. Other than this I did not come in contact with him at all. He called on me some

four or five times after this for treatment which I gave him with no good results, but observed the same caution each time not to expose myself to infection.

But some five or six weeks after commencing his treatment I began to feel the same symptoms my patient complained of. Then my wife took it, and lastly my daughter. We tried many things, both internally and externally, to no purpose. We were at times nearly insane and discouraged with the terrible annoyance.

Nothing could be seen only that the skin was roughened, but after scratching violently there were seen little papulæ about the size of this mark o, and as though split through the centre. The itching of these points was excessive. These papulæ were rather thinly scattered. We scraped the skin and examined the scurf with a microscope of good power, with only negative results.

My patient, on coming to me first, said he was afraid it was contagious, and that he thought he had contracted it from a suit of underclothing he had bought, as it appeared on him soon after that and he was certain he had not been otherwise exposed. He was of the opinion that some person having the disease had tried the clothing on previous to his buying it. I am not aware of communicating it to any person outside of my own family.

The symptoms were very peculiar. The face was affected as much as any place, and particularly about the eyebrows. It was common to feel as though a hair was being drawn rapidly across the face. At other times it felt like a small insect moving slowly across the face, but nothing could be either felt or seen.

A wash of the sulphite of soda was about the most useful application. Sometimes that would afford no relief and glycerin would give great relief. Then it would fail, and so on. I found arsenious acid, $\frac{1}{2}$ grain, after meals, and nux vomica, $\frac{1}{2}$ grain, before meals, gave astonishing relief and I thought we were cured, but after a while that gave out and was of no use, though I increased the dose until I could no longer bear the effects of the drugs. I then took iodide of potassium and was instantly relieved by moderate doses—about one grain three times daily. After some months this gave out and I returned to nux vomica and ars. with relief and then to iodide of potassium again. After some months I got rid of it and have not been troubled now for three or four years. My patient was cured with the arsenic and nux vomica alone.

I have always thought the disease was parasitic, but could not demonstrate it; but the fact that it was cured in all the cases by internal treatment would seem to contraindicate that diagnosis. I am yours respectfully, J. G. M.

FLINT, MICH., October 4, 1882.

Received.

PAMPHLETS.

The Treatment of Syphilis with Subcutaneous Sublimite Injections. By DR. JOHN V. SHOEMAKER. (Reprint.)

The Oleates and Oleo-palmitates in Skin Diseases. By DR. JOHN V. SHOEMAKER. (Reprint.)

The Question of Contagion in Leprosy. By DR. JAS. C. WHITE. (Reprint.)

Report of the Board of Managers of the American Hospital for Skin Diseases, Philadelphia, 1882.

Items.

BROMIDE OF POTASSIUM INJECTION FOR GONORRHOEA.—

R. Aquæ.....	3 v.
Glycerini.....	3 iiss.
Potassii bromidi.....	3 iss.
Tinct. opii.....	3 ss.

M.

The purpose of this injection is to relieve the distressing nocturnal erections associated with gonorrhœa. The urethra should be injected four times daily, the last injection before retiring.

The solution should be permitted to remain in the canal at least one or two minutes, otherwise its effects are unsatisfactory.—CHAMBILLIARD.

THE NEW YORK DISPENSARY FOR DISEASES OF THE SKIN

has removed to 209 to 211 East Twenty-third street. Open on Monday, Wednesday, and Friday at 2 o'clock.

A DERMATOLOGICAL DRAMA.—The *Moniteur des Sciences Médicales et Pharmaceutiques* publishes an amusing "dermatological drama," called "King Sulphur" which is said to be played at the Hôpital St. Louis. Sulphur is King of Cutis, and has just conquered Acarus. He lays his crown at the feet of Queen Friction, who has aided him in the campaign, and implores her to become his honored queen. But she insists first on making an assault on Favus, and totally destroying his arrogant rule. If afterwards Sulphur should burn with the same ardor she will consent. Then she leads forth her army, attended by Axungia, while Sulphur marches in her train. Meanwhile the old-tried Generals Hydrargyrum, Iodide of Potassium, and Turbith consult in angry conferences. Hydrargyrum is excited when he thinks that he, who has for forty years combated with so much glory all the forces of the Syphilides, should now be set aside for this Sulphur. Iodide laughs at his fears, and mocks at the silly tactics of Sulphur in such a war. Then we are introduced to the palace of Queen Eczema, wife of Herpes, who confides to her faithful attendant Acne her fears as to the future; she imagines she is losing her bloom, and is oppressed with vague fears. The news of the advance of Sulphur with Friction and Axungia causes vast alarm. Great preparations are made to resist him, but his attack is irresistible, and at length Favus, Eczema, Herpes, and all their generals have to acknowledge themselves vanquished by this terrible parasite and spore destroyer.—*Chemist and Druggist*.

CO-EXISTENCE OF SCARLATINA AND VACCINIA IN THE SAME SUBJECT.

—The simultaneous development of two eruptive fevers in the same subject has been doubted by many celebrated men, but no less eminent persons than MM. Roger and Bergeron have demonstrated the possibility of its existence. The observations of Dr. Fabre are fresh proofs of the verity of the latter theory. Scarlatina in a child, which was the subject of this phenomenon, appeared on the second day of the vaccinal eruption, and followed the usual course. Thus the two exanthemata developed themselves simultaneously in the same subject; so the case of M. Fabre is an incontestable proof against the theory that the co-existence of two eruptive fevers is impossible in the same subject, which was first put forward by Hunter.—*Med. Press and Circ.*, June 7, 1882.

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Original Communications.

ON EXCISION OF THE CHANCRE AS A MEANS OF ABORTING
SYPHILIS.¹

BY

P. A. MORROW, M.D.

IS it possible, by excision of the initial lesion, to destroy the syphilitic virus and prevent infection of the general system? Such is the question which, at the present time, is engaging the serious attention of syphilographers both in this country and Europe.

Perhaps no problem connected with syphilis has been found so difficult of definite solution as the prophylactic value of destruction of the chancre. From the time of Jean de Vigo (1503), who recommended cauterization, until the present, the idea that the syphilitic virus might be entirely suppressed, or the severity of its constitutional effects modified, by destruction of the primary sore, has been received with more or less favor by the profession. John Hunter, who regarded the chancre as a purely local affection, was accustomed to cauterize or extirpate it. This was also the practice of Benjamin Bell, who refers to this mode of treatment as the one generally employed at his time. Ricord was for many years a most enthusiastic advocate for the early destruction of the chancre, either by caustics or excision, and we may regard it as the almost universal practice until a comparatively recent date. Within a few years past, however, we find that professional sentiment has undergone a complete change in this regard. The principles upon which the abortive

¹ Read before the New York Academy of Medicine, November 16, 1882.

treatment was based have been generally recognized as founded in error; it has ceased to be recommended in standard text-books, and its practice virtually abandoned.

In 1877, however, a communication published by Auspitz and Unna, reciting many cases in which they had excised the initial lesion, with the result of preventing constitutional manifestations, gave a fresh impulse to the examination of this question. Since then, numerous excisions have been made by different experimenters, with results more or less favorable, the bearing of which, upon the question at issue, we propose to consider in this article.

In Germany, where the so-called abortive method of treatment was revived, we find that the current of professional opinion is largely in its favor. Among its partisans are numbered some of the most prominent specialists, such as Auspitz, Unna, Kölliker, and others—men whose position in the medical world invests their opinion with the weight of high authority. In France, it has by no means received the same prompt recognition and favor, its advocates are fewer in number and urge its claims with less pretension. In England, the operation seems to have been practically ignored, or its results have not been of so brilliant a character as to justify their publication; at least we find no mention made of them in the current British journals. In this country, excision does not seem to have been often practised. Some of our specialists have expressed themselves guardedly in its favor in certain selected cases, but the general sentiment seems to have been adverse to its adoption as a means of cure.

Before entering into an examination of the arguments urged for and against this method of treatment, let us state the position and claims of the partisans of excision. The operative procedure may first be briefly described. The chancre is firmly grasped with a pair of forceps or tenaculum and uplifted so as to put the parts on the stretch. The indurated mass is then removed by a clean sweep of the knife, with an area of healthy tissue immediately surrounding it. Formerly curved scissors (Hüter's) were used, but they have been laid aside for the knife. The wound is then sutured and covered with carbolyzed dressings, and a compressive bandage applied to prevent swelling. Usually there is but little hemorrhage, and the wound often heals by first intention. The loss of tissue rarely occasions much deformity or interference with the function of the part. Not infrequently a subsequent induration occurs in the cicatrix, which is accepted by most operators as an indication for its removal by a second excision.

While admitting that the rationale of the operation involves nothing new in principle, the excisionists claim that they effect thoroughly and completely with the knife what was imperfectly done by caustics and

other means; asserting that it is difficult, if not impossible, to penetrate to the bottom of the indurated mass and radically destroy certain chancres, even with powerful caustics or the hot iron.

They claim that, in a large proportion of cases, excision of the chancre effects a radical cure of syphilis; a cure attested by the fact that the most careful surveillance, continued through a period of months or even years, fails to detect the slightest constitutional manifestation of the disease; a cure rendered certain, beyond all possibility of doubt, by the patient's susceptibility to a fresh inoculation of the syphilitic virus, as frequently demonstrated by experiment.

They claim further, that even where a complete destruction of the virus is not effected by excision of the chancre which contains it, that it becomes attenuated, emasculated, deprived of its potentiality for mischief, so that the resulting syphilis will be of a milder type, as shown by the delay in the appearance of secondary symptoms and their general character of benignity.

Another advantage claimed for excision of the chancre is that, even though its abortive effects be negative, even though it fails to arrest the diffusion of the poison through the system, still it is to be recommended as a local adjuvant; it acts advantageously by converting a hard unhealthy sore into a simple wound which often heals by first intention.

The indications for excision are not precised with clearness, but are variously stated by the different operators. Obviously enough, the earlier the excision is done, the greater the chances of the patient's escape from subsequent infection. By Auspitz, Kölliker, Hüter, and others, the induration of the chancre, even consecutive adenitis is not regarded as a contra-indication of the operation. They assert that it may be undertaken, with hope of success, at any time previous to the appearance of secondary symptoms. Some of its more enthusiastic advocates recommend excision of the involved glands as well as the initial sclerosis.

From a theoretical stand-point, the whole question hinges upon the determination of the nature of the primary sore. If, as is contended for by the partisans of excision, the syphilitic virus remains localized at its point of entrance during the period of the first incubation, its primary effect being limited to the development of the chancre, from which the system does not become infected until after the second incubation, then it is quite possible, by removing the *dépôt* of the virus, to prevent constitutional contamination.

If, on the other hand, the initial lesion be the local expression of a constitutional condition, the evidence of an already accomplished infection, which follows immediately the inoculation of the virus, then it is manifestly impossible, by excision or other local means, to arrest or modify its effects upon the general system.

In endeavoring to appreciate the pathological character of the initial lesion, we are embarrassed by our absolute ignorance of the nature of the virus which produces it. Whether the infectious principle be a pathological ferment, a micro-organism, or some other undemonstrated specific entity, we can only conjecture. It cannot be isolated and examined by anatomical or chemical tests; the most minute microscopic analysis fails to detect its presence in the fluids which contain it; our knowledge is altogether limited to its effects upon the organism.

As regards the physiology of syphilitic infection, much has been written, and many theories broached. We will not consider at length the mode of penetration of the virus into the economy, whether through the intermediary of the lymphatic vessels, as has generally been claimed, or whether by gradual implication of the blood-vessels contiguous to its point of entrance, as has been asserted by Auspitz and Unna. We are concerned with the celerity rather than the course of its passage.

To bring the points of issue prominently into relief, let us consider the ordinary evolution of syphilis. It may be stated:

That the first appreciable phenomenon, which results from the inoculation of the syphilitic virus, is always manifested at the point of infection after a period more or less prolonged, on the average from three to four weeks (period of first incubation).

That this primary lesion constitutes for a time the sole sign, the unique expression of the disease.

That after a certain lapse of time, during which the contiguous lymphatic glands undergo an indolent enlargement (period of second incubation), there is an eruption of the so-called secondary symptoms, which may be generalized over the entire body.

Now, the question arises, At what particular time does generalization of the virus take place; at the moment of inoculation, with the apparition of the chancre, with the engorgement of the lymphatic glands, or immediately preceding the explosion of general symptoms? At the first glance, it would seem that the theory upon which the practice of excision is based was the correct one. Judged by its visible manifestations, and the regular order of their succession, the syphilitic virus remains latent, more or less inactive, for a time, at its point of entrance. It is powerless to proceed further, until it has gathered strength by repose and germination. Its first effect is irritation of the cells in immediate proximity, resulting in the hyperplasia which constitutes the initial sclerosis. This proliferation of cells continues affecting, first, the *adventitia*, then the *intima* of the contiguous vessels. By gradual implication of the vessels, the poison proceeds until it reaches the nearest lymphatic glands; here, after another period of repose and multiplication of cells, it gains an added potentiality which enables it to invade the entire organism. This concep-

tion of the evolution of the disease regards the chancre as the depôt of the virus, within which for a certain time it is encapsuled, so to speak, and from which, as a source, infection propagates itself to the entire system. To excise the chancre, then, is to suppress the source of contagion.

The theory that the action of the virus is primarily limited to its point of insertion is further supported, it is claimed, by analogy. Tuberculosis, for example, has been referred to as having many points of similarity with syphilis, and the well-known experiment of Conheim has been cited, who introduced into the anterior chamber of the eye of a rabbit a drop of tuberculous matter, and watched the result. Absolutely no change occurred until the eighth day, when he observed a congestion, with subsequent formation of tissue, analogous to that of tubercle. Tuberculous masses were afterwards found in the lungs and other organs. In this case general infection did not take place until after an incubation of eight days. Cancer, it is claimed, shows in its primary development as a local disease, and subsequent invasion of the system, a resemblance to the evolution of syphilis.

The theory of immediate infection, through the lymphatics, is objected to by Auspitz, on the ground that it involves the assumption that the virus first traverses the lymphatic system, enters the general circulation, then returns to develop the characteristic lesion at its point of entrance, and then slowly, for the second time, makes its way along the lymphatic vessels, producing irritation, engorgement, and other changes. If the virus be generally diffused through the system, why should it always first manifest its presence at the point of inoculation and not at another portion of the integument? Again, if the disease be a constitutional one from the first, why await the appearance of the inevitable secondary symptoms before commencing the administration of specific treatment?

Finally, the partisans of excision justify their practice upon clinical experiment, the results of which will be examined later.

Opposed to the theory upon which the practice of excision is based, there are many facts drawn from analogy, from experiment, and from clinical experience.

So far as our knowledge of the mode of action of the *contagia* of other diseases, the acute exanthemata for example, may throw light upon the operation of the syphilitic virus, it tends to confirm the assumption that infection takes place from the moment the virus gains access to the system. In these diseases, although infection immediately follows exposure, there is at first no derangement of the general health, indicated either by local or general symptoms, and the effects only declare themselves after a period of incubation, more or less prolonged, ac-

according to the nature of the specific poison and the reaction of the organism.

The vaccine virus affects the system in a manner analogous to that of the syphilitic virus. They both produce lesions at the point of inoculation, which appear after a certain period of incubation. These lesions, the matured pustule and the initial sclerosis, each represent the acme of development of the morbid process producing them, and should, in one case as in the other, be considered evidence of the complete saturation of the system. In regard to the vaccine virus, it may be considered as definitely settled by the experiments of Bosquet and Steinbrenner that, from the moment of its inoculation, it is rapidly absorbed and general infection begins. These experiments are supplemented by those of Aime Martin (1863), who vaccinated seven children, and cauterized the punctures at intervals ranging from one to twenty hours after the inoculation. Although the cauterization prevented the development of typical pustules, it none the less failed to arrest the diffusion of the virus through the system, as shown by insusceptibility to revaccination. Monneret vaccinated fourteen cases, and revaccinated them from the first to the eighth day afterward. The second operation failed to produce vaccinal pustules when performed later than the second day. These experiments would seem to show conclusively, that "receptivity is extinguished even before the appearance of any eruptive accident." Analogically, we might infer the same for syphilis. Whether the syphilitic virus permeates the system so completely, before the appearance of the chancre, as to exhaust its susceptibility to a fresh inoculation, is not pertinent to our present inquiry; and, besides, is of no practical value, as we have to deal with the disease only after the development of the primitive accident. The important fact that the chancre is not inoculable upon the person bearing it, has been abundantly proven by numerous experiments. Among the hundreds and thousands of cases in which auto-inoculation has been attempted, the successes recorded have been so insignificantly few that they cannot be held to invalidate the proposition that the chancre is, as a rule, non-auto-inoculable.

Experiments with the virus of other diseases might be referred to, illustrating the instantaneity of absorption. Renault d'Alfert inoculated twenty-two sheep with the sheep-pox poison, and although the wounds were thoroughly cauterized within from five to thirty minutes after inoculation, the animals were all attacked with the disease. The same experimenter inoculated thirteen horses with the poison of glanders. The wounds were all cauterized within short intervals, varying from one to twenty-four hours afterward, yet they all died from the disease.

Glanders has certain analogies with syphilis. The so-called horse-chancere manifests itself at the point of inoculation, after a period of

incubation. There is a subsequent swelling of the nearest lymphatic glands, and later, the characteristic nodules become generalized.

Cauterization of the bite of a mad dog, though done immediately, and with all possible thoroughness, does not afford protection against hydrophobia. Other examples might be adduced, all tending to prove the utter uselessness of attempting to arrest the diffusion of a poison when once it has gained entrance to the circulation.

Turning now from the teachings of analogy and deductions drawn from experiments with animal poisons, let us examine the results of clinical experience. We have seen from a glance at the literature of syphilis that the theory of the local nature of the chancre was formerly generally accepted by the profession, and, as a logical sequence, its destruction by caustics or other means was the classic treatment. Benjamin Bell, who wrote in 1793, says: "The practice of healing chancres by the internal use of mercury originated from an opinion that venereal sores proceeded from the constitution being infected, and, were this the case, there might be cause to consider it well founded, but now that we know that chancres are always *local*, and that they are the *source* of whatever matter enters the system, it is obvious that the more speedily they can with propriety be healed, the less will be the risk of the constitution being injured." John Hunter may be quoted to much the same effect. Ricord says: "If chancre be at first a local affection, as Hunter asserts, and as observation and experience prove it to be, we must be consistent, and treat it as everybody treats the bite of a mad dog, that is, destroy the local disease as soon as possible." Again he says: "The primary influence of the infecting chancre being limited to the region which it affects, general infection is not an immediate and instantaneous result; it is an accident consecutive to the development of the chancre, and which requires a certain time to produce itself. In destroying a chancre at its *début*, a chancre which is about to become indurated, you can at the same stroke exhaust the source of constitutional infection. . . ." "Excision may effect what cauterization does; it is in fact an excellent method which suppresses the chancre at a single stroke." He declares "that of all the chancres which I have seen cauterized or I myself have cauterized from the first to the fourth day of contagion, not one has been followed by symptoms characteristic of constitutional infection." Sigmund's testimony upon this point is equally emphatic. He says "the observation of more than a thousand cases in a period of eleven years has shown me that never have secondary accidents declared themselves when the chancre had been completely destroyed within the first four days."

Statements so strong and positive, coming from the leading representatives of the French and German schools, are in startling contrast with the results of treatment at the present day. But from the advanced

stand-point of our knowledge of the normal evolution of syphilis, we know that these claims are based upon a wrong interpretation of clinical facts. Inoculative experiments, as well as clinical observation, prove conclusively that a period of incubation, on the average twenty days, always intervenes between the reception of the virus and the appearance of the initial lesion, and when Ricord speaks of cantherizing a chancre from the first to the fourth day after contagion, he utters an absurdity, for the obvious reason that the chancre has no existence at that time.

It will be granted that evidence drawn from clinical experience before the distinction between chancre and chancroid was recognized is without value, since the destruction of a venereal sore and the subsequent immunity of the patient from syphilis, do not necessarily stand in the relation of cause and effect. If the sore happened to be a chancroid, constitutional manifestations would not have followed in any case; hence the exemption from syphilis would argue, not the efficacy of the treatment, but the non-infectious character of the sore. Even after Basserau had enunciated his dualistic theory, and indicated with precision the characteristics which differentiated the two forms of sore, we find that Ricord still advocated the abortive treatment, but with a limitation as to its applicability. He had modified his former views as to the chancre being the source of infection, and taught that the treatment, to be effective, must be applied before induration takes place. He says: "From the moment that induration is produced, the disease is acquired, and from that time you may cauterize or you may excise the chancre, you only destroy a symptom without preventing the diathesis. It is, therefore, less appropriate to regard the induration as the origin of the syphilis than to consider it a consequence; it is less a cause than an effect."

The rule of treatment laid down by Ricord, it may be remarked, is coupled with a condition which is equivalent practically to a rejection of all abortive attempts, except in those rare cases where confrontation is possible. All syphilographers recognize the fact that there are absolutely no distinctive signs which would enable the most skilful diagnostician to pronounce upon the syphilitic character of a venereal sore before induration takes place. Fournier says "the incipient chancre is the most insignificant of erosions, an erosion without distinctive character, without special physiognomy, absolutely deficient in every sign sufficient to differentiate it from a common erosion. . . . When one has cauterized an incipient chancre, one never knows certainly what he cauterized." He concludes that "cauterization, destruction of the chancre as a preventive, abortive means against syphilis, is purely illusory. To suppress the chancre is not to suppress the diathesis. The diathesis is acquired when the chancre is produced, and the chancre in definitive is only the first phenomenon of confirmed syphilis." Even when it is pos-

sible to determine the syphilitic character of a sore upon its first appearance by confrontation, the facts of clinical experience teach us that its immediate destruction would offer no guarantee against the subsequent development of constitutional symptoms.

Attempts to neutralize the effect of the syphilitic virus by disinfecting washes applied immediately after contact, have proven notoriously unsuccessful. In this connection, we may quote a case reported by Jullien of a physician whose finger, upon which there was a minute abrasion, came in contact with the chancre of a patient he was examining. "The moment Dr. X. perceived it, he had recourse to the most careful and thorough washing, and endeavored to remove from the wound everything which had been deposited on its surface. It was in vain; the progress of the virus had already commenced, and infection followed its course. This fact, which the scientific position of its author places above all doubt, establishes categorically, it seems to us, that absorption begins at the same time that the act of contagion takes place."

Berkley Hill cauterized with fuming nitric acid a torn frænum within twelve hours after intercourse, nevertheless an indurated sore appeared twenty-eight days later, followed by general symptoms. Langston Parker reports a case where a chancre was effectually destroyed within one hour after its appearance, yet a more severe attack of syphilis followed in due time. Diday applied caustic to a chancre within six hours after its appearance, the sore healed kindly, but general syphilis followed after the classic delay. But why multiply instances? Medical literature abounds in cases where the most energetic destructive treatment, from the moment the chancre appeared, utterly failed to prevent or even retard the outbreak of constitutional symptoms.

From the foregoing considerations, and others which might be cited, the large majority of syphilographers have come to believe that it is contrary to the teachings of analogy, contrary to the facts of experiment, that a virus introduced beneath the integument should remain for several weeks isolated in the tissues without mingling with the blood or lymph; while careful clinical observation, based upon a clearer comprehension of the laws of infection and the relations of the chancre to general syphilis, has culminated in the conviction that destructive cauterization is absolutely useless as an abortive measure.

Upon these points there is a remarkable unanimity of sentiment among authorities, as reference to standard text-books on Venereal will show. Cazenave, Rollet, Langlebert, Diday, Fournier, Jullien, Bärensprung, Lewin, Zeissl, H. Lee, Bumstead, Keyes, and others all testify to the same effect. Finally upon this point may be quoted the latest utterance of the eminent syphilographer, whose genius has solved so many of the difficult problems connected with syphilis, and whose name is identi-

fied with every important advance made in the progress of this specialty during the last half-century. In an oral communication to Leloir (*Annales de Dermatologie et de Syphiligraphie*, 1881), Ricord declared "that he was completely converted from the practice of cauterizing or excising chancre. He regarded the destruction of the infecting chancre as absolutely useless at whatever epoch of its existence it may be. As soon as it has appeared, before its appearance even, syphilis exists. In vain you might amputate the patient's penis on the appearance of the infecting chancre, syphilis would none the less declare itself."

From this survey of the subject, we perceive that the verdict of enlightened experience condemns the cauterization of the chancre as a prophylactic measure, and so far as clinical experience can settle a question, it may be considered settled by the overwhelming testimony of careful and competent observers. But, on applying this evidence against the practice of excision, we are confronted with the assertion that the cases are not parallel, that extirpation of a chancre with the knife is radically different from its destruction by caustics. While failing to appreciate the force of this argument, which seems to be based upon a distinction of means rather than upon a difference of effect, we will now examine the published results of excision as bearing upon the question at issue.

Obviously enough, this examination can embrace only a small proportion of all the cases in which excision has been performed, as we have seen that it was a recognized procedure among the older specialists. But these earlier records, even were they available, would be without value, since, as before pointed out, testimony as to the results of abortive treatment before the line of separation between chancre and chancreoid was rigidly drawn, is untrustworthy. Coming now to recent times, we find that Humphry and Neale, in 1864, strongly recommended excision of the chancre, but they fail to publish results which would enable us to appreciate its value from a statistical stand-point. The tabulated list which follows, includes all cases reported in the various medical publications accessible to me since 1867.

OPERATOR.	(AUTHORITY.)	NO. OF CASES.	SUCCESSES.
Hüter (Berliner klin. Wochenschrift, 1867).....		8	2
Langenbaeck (Idem, 1867).....		2	1
Coulson (Treatise on Syphilis, London, 1869).....		1	0
Thiry (Presse Médicale Belge, 1870).....		1	0
Kuzlinski (Thèse de Greifswald, 1874).....		1	1
Caspary (Vierteljahresschrift f. Dermat. u. Syph., 1876).		3	0
Auspitz u. Unna (Idem, 1877)		33	14
Köl liker (Centralblatt für Chirurg., 1878).....		8	3
Prospelow (Moscow Med. Gaz., 1878) ..		3	3
Rydgier (Leczenie Chirurg., 1879).....		3	2

OPERATOR.	(AUTHORITY.)	NO. OF CASES.	SUCCESSES.
Pick (Arch. f. Ex. Pathol. u. Pharm., 1879).....		1 + ?	1
Folinea (Il Morgagni, Tome XXI., 1879).....		19	8
Klink (Medycyna Varsovie, 1879)		5	0
Chadzynski (Annales de Dermat. et Syph., 1880).....		30	7
Zeissl (Wiener Med. Presse, 1880)		5	0
Mauriac (Annales de Dermat. et de Syph., 1881).....		11	0
Quinquard (Idem, 1881).....		3	0
Terillon (Idem, 1881).....		1	0
Gibier (Idem, 1881).....		2	0
Jullien (Trans. Internat. Med. Congress, 1881).....		5	1
Rasori (Giorno Ital., 1881).....		1	0
Bifani (Giorno Ital. dell. Scienze Med., 1882).....		3	2
Spillman (Annales de Dermat. et de Syph., 1882).....		8	2
Bumm (Vierteljahresschrift f. Derm. u. Syph., 1882)...		27	5
Beevan (Md. Med. Journ., 1882).....		8 + ?	8
Bumstead and Taylor (On Venereal Diseases, 1880)		15	0
Otis (oral communication, 1882).....		15	0
		<hr/> 222	<hr/> 60

To sum up, there are claimed 60 success in 222 cases, or about 25 per cent. By success is understood the non-appearance of secondary accidents during a period of observation continued from four months to one or more years.

It may be remarked that the force of the foregoing statistics is materially weakened by a number of qualifying conditions. We cannot, of course, take up these cases *seriatim* and analyze them, stating the grounds of their authenticity, and pointing out possibilities of error which would impair their value or lead us to reject them altogether, but we may, in general terms, indicate certain objections.

In the first place, it is to be borne in mind that a number of the experimenters are *unicists*, and believing as they do in the etiological identity of chancre and chancroid, it cannot be supposed that the sores were differentiated with that absolute exactness which would allow the results to serve as a criterion of the prophylactic value of excision. The same objections which were urged against the validity of the earlier results claimed by Ricord and others for cauterization would apply in this case.

In the next place, we will observe that many of the cases should be rejected on account of the doubtful character of the diagnosis. Confrontation, the most important element of certainty in diagnosis, was employed but seldom. Among the cases reported as successful in which excision was performed eight, nine, and ten days after exposure to contagion, the correctness of the diagnosis is open to serious objection. The appearance of the chancre at that epoch, though not impossible,

is altogether exceptional and opposed to what we know of its normal evolution. Even admitting its existence at that time, all syphilographers will testify to the exceeding difficulty, if not the absolute impossibility, of pronouncing upon its syphilitic character before induration and engorgement of the inguinal glands takes place. Even then the diagnosis is not certain; the induration may be inflammatory, and the glands sympathetically swollen. It is a fact verified in the experience of all of us who have much to do with syphilis, that oftentimes a lesion presenting the typical induration and other characteristic signs of chancre, though subjected to only the simplest local treatment, is not followed by general syphilis. So frequently do such mistakes occur that most authorities recommend the postponement of specific treatment until the diagnosis is confirmed by the appearance of secondary symptoms. Another source of error which depreciates the value of the statistics is the insufficient observation to which the patients were subjected after the operation. In many of the cases, the observation was continued only four or five months—a period manifestly too short to justify a conclusion of the patient's exemption from syphilis. Again, many of the patients were seen only monthly, or at longer intervals, while, in some of the cases, the claim of success was based upon the patient's statement, twelve or eighteen months later, that he had been free from syphilis. Any one familiar with the evolution of secondary accidents, their sometimes insignificant character, their susceptibility to pass unperceived by the patient, and the tendency of the disease to manifest itself in cyclical explosions, with intervals of repose and entire freedom from all symptoms, will at once appreciate the possibilities of error in such conclusions.

In a number of cases, excision was performed from twelve to forty-eight hours after the appearance of the chancre; the general average was from seven to nine days. Now it would naturally be supposed that the immediateness of the operation is the prime condition of success, yet, in Rasori's case of excision of a chancre situated upon the prepuce, twelve hours after its appearance; in Gibier's and Mauriac's cases, forty-eight hours later, and in others where excision was done from the second to the fourth day, general syphilis followed in due time.

Another claim which may be set aside as not proven is that, though excision may fail to prevent constitutional syphilis, yet by removing the mass of infected cells contained in the chancre, the virus is attenuated, and the severity of the disease modified. There is no evidence that numerical diminution of the germs of an infectious disease will deprive it of its power of thoroughly impregnating the system. Experience proves that the mildness or severity of the disease is a matter of individual constitution; that the *quality* of the syphilis is dependent upon the reaction

of the organism rather than the *quantity* of virus implanted. Besides, these observations are restricted to a period which comprises only secondary accidents, and even admitting that these were mitigated in severity, yet we know that the initial benignity of a syphilis confers no guarantee against the malignancy of tertiary manifestations. As Fournier has pointed out, the worst possible forms of tertiary syphilis, with tendency to localization in the brain and other central organs, are characterized by the exceeding mildness of secondary accidents.

A final objection to the practice of excision from a surgical stand-point. We know that the chancre is a lesion essentially benign, occasioning little pain or other subjective symptoms, self-limited, with a tendency to spontaneous resorption, and healing, generally, without cicatrix. It is opposed to the principles of conservative surgery to intervene with an operation which involves hemorrhage, loss of tissue, deformity, and an indelible cicatrix, in order to effect that which is surely and painlessly accomplished by the unaided forces of nature.

From this study of the subject we conclude:

1st. That the facts of clinical experience, as well as deductions from analogy and experiment are opposed to the theory of the local nature of chancre upon which the practice of excision is based.

2d. That the practice of excision of the chancre, as a means of aborting syphilis, is condemned by its clinical results, when these results are weighed in the balance of discriminating judgment, due regard being had to the possibilities of error.

3d. That these sources of error are comprehended under doubtful diagnosis, insufficient observation, both as regards time and method, and *post hoc* conclusions.

4th. That in cases where secondary accidents fail to appear after excision, there is no positive evidence that it had an abortive influence, since experience proves that sores with all the typical signs of infecting chancre are sometimes not followed by constitutional syphilis.

5th. That there is no evidence that excision of the chancre attenuates the syphilitic virus and modifies the intensity of general symptoms, since the benignity or malignancy of syphilis is a matter of individual constitution.

6th. That it cannot be recommended as a local adjuvant, since it is opposed to the principles of sound surgery to remove, by an operation involving loss of tissue and an indelible cicatrix, an accident which always disappears by a process of spontaneous resorption, leaving, as a rule, no posthumous evidence of its existence.

A CLINICAL STUDY OF DERMATITIS PAPILLARIS CAPILLITH.

BY

J. NEVINS HYDE, M.D.

(Continued.)

THE second case which came under my observation, was presented at my clinic at the College on the 6th of February, 1882. It was there made the subject of some remarks, but unfortunately was not again presented for study. The notes of the case therefore are limited to those taken upon this single occasion, in connection with the statements made by the physician who accompanied the patient.

M. H. is a twelve-year-old female child of parents in fair health. The mother has never miscarried, and has borne two other children now in good health. The patient has suffered from her present disorder for one year and a half. She has never had any other illness which can be remembered. The disease commenced upon the scalp to which it is yet limited, never having invaded any other region. "Pimples," occurring at irregular intervals, were first noticed near the vertex, and gradually produced the condition which is now noticeable. Since the disorder of the scalp has attained its present stage, no very marked alteration in it has occurred. The disease has been treated by several physicians, one of whom, thinking that he could distinguish pulsation in the growth, pronounced it aneurismal in character. Various internal and external methods of treatment have been employed, all without effect upon the local disease. The child is fairly well developed and nourished, and has red lips and some color in the cheeks. Upon questioning her parents, no history can be obtained of any symptoms of disturbance of her bodily functions. They declare that her appetite is good, that her dejections are regular as to time and natural in character, and that she amuses herself in the manner customary among girls of her age.

Upon examination, the following was established as the condition of the scalp. Situated in the median line, its upper limit near the vertex, its lower extending well down to the occiput, is a palm-sized elevation of the surface. Its contour is quite irregular, being represented by a circle, here and there broken in design without, however, producing marked prolongations at the periphery. The lesion is distinctly circumscribed and surrounded by a growth of vigorous hairs which have been clipped short near the surface of the scalp. Its elevation above the level of the latter scarcely exceeds at any point the width of the thumb, but varies in different parts of the surface. In other words, the summit of this plaque, or exceedingly broad-based tubercle or (if it may be properly so termed) aggregation of tubercular lesions, is exceedingly irregular. Its plateau is comparable to that produced by a series of rolling hills, with shallow valleys between them. Its color is a grayish-red, being but little heightened above that of the healthy scalp about it. Here and there, very

irregularly arranged upon the surface, the hairs are associated in sparse wisps, tufts or bunches, the greater part of the plaque, however, being quite destitute of hairy growth. The hairs in these wisps or bunches are of the lanugo type, short, feeble, rather lighter in color than upon the remaining portion of the scalp, and resembling those produced in the first crop after efficient epilation of a hairy surface. None of them are loose in their follicles, brittle, fractured, or represented by stumps. A few of these, as also of those at the periphery of the region, were placed under the objective of the student's microscope which is employed at the clinic for the purpose of diagnosis. No parasites were thus discovered.

As already intimated, the larger part of this plaque or compound tubercle was quite destitute of hairs. In many parts the orifices of the empty hair-follicles could not be distinguished by the eye, in others, they could be recognized as either indolent, funnel-shaped, shallow depressions directly exposed to the view, or covered by little heaps of dried sebum. These accumulations of sebaceous material upon the surface were very irregular, a few streaks or bands of yellowish-gray or reddish-gray sebaceous material being discernible upon the surface. There was no offensive odor to this secretion.

In firmness, this patch exhibited considerable variation.

In places it resisted the finger with a cicatricial density, in others (and this chiefly in the central region which suggested to a certain extent that here there had been some involution in process) the tissue was decidedly soft to the touch. Over a part certainly, this softness or softening produced the impression of indistinct fluctuation. It was this feature which had probably suggested the idea to one of the physicians who had previously examined the scalp that the lesion was aneurismal in character. By the most careful examination, however, no pulsation could be detected, and no aneurismal bruit was audible. When a needle was thrust into the centre of this softish mass, its withdrawal was followed by a discharge of thin, venous blood and serum; the growth was not tender; there was a history of no painful subjective sensations.

The surface of the body elsewhere, being carefully examined, disclosed no evidences of disease either past or present. There were no cicatrices upon any surface. The central incisor teeth did not present the changes described by Hutchinson as characteristic of inherited syphilis.

Viewing these cases comprehensively, a fair idea may be gained of the origin and career of this disease, which would seem to be somewhat polymorphic in its manifestations. Before, however, reverting to these features in order to present a clinical picture of its general characteristics, I desire to dwell for a moment upon one particular symptom which requires special attention. This is the papillary, vegetating, or wart-like appearance which the disease may at times assume. I believe that this is an accidental and not an essential part of its clinical history.

Kaposi, Alibert, Rayer, and Hebra describe papillomatous growths springing from the areas affected by the disease, while by others, including myself, these symptoms have either not been observed or occurred in less marked degree. The indefiniteness, however, to which attention has been directed, attaching to the meaning of the term papilloma, may be

responsible for a part of this difference. For example, the dense, flattened, keloid-like plaques observed by me in the cases here reported, have not been named papilloma; and it will be observed that the French authors have, apparently with a purpose, avoided the use of the same term.

The following cases are cited in illustration of the condition to which the term papilloma is commonly applied by dermatologists. The lesions described belong to either the verrucous or symptomatic varieties of papilloma, as these are defined by Hardaway (*loc. cit.*). Although occurring upon the hairy scalp, and upon that region of it particularly which has been shown to be the site of election of dermatitis papillaris capillitii, in each there was wanting the pathognomonic symptoms of the last-named disease.

Mrs. F., æt. thirty years, mother of two healthy children, was brought to me by her husband, a laboring man, in September, 1881. He gave one of those obscure histories of syphilis before marriage which are sufficiently common in a physician's experience, and which it is often impossible to verify by clinical facts. He was a vigorous man, absolutely without symptoms of disease. His wife had been married six years, and she also presented the evidence of general good health. She was, at the date of this examination, in the sixth month of pregnancy. Immediately above the border of the scalp at the nucha and in the median line, surrounded by long, dark-brown and vigorous hairs, was a pedunculated mass as large as a horse chestnut. It was globular in shape and covered here and there with a moist secretion which in places had dried upon it and had also matted together somewhat the long hairs in the vicinity. Its odor was to a marked degree repulsive. She complained that it was annoying in consequence of the traumatisms to which it was subjected by the various contacts of her daily life. It was somewhat tender on pressure and had bled slightly on one or two occasions. A moderate quantity of a purulent fluid could be expressed from it with the fingers. It was reddish-brown in color, when freed from the mucus and partly dried pus with which it was covered. Its surface did not exhibit lobulations, but was generally papillary in form, suggesting the cauliflower appearance in its moist, club-shaped, symmetrically rounded, warty masses. She stated that she did not remember to have noticed it prior to the beginning of her pregnancy, since which date it had reached its present development. A probe passed flat-wise beneath the overhanging edges of this vegetation, demonstrated the existence of a relatively slender stalk or pedicle by which it was attached to the scalp.

About this I passed a wax ligature which was firmly secured in place. Inspection, however, in the course of two weeks, showed that the mass had been but partly strangulated. The ligature was consequently reapplied, and, as the result of this, the mass withered and exfoliated. Subsequent observation of the small cicatrix, which formed, disclosed entire absence of all sclerosed masses or keloid-like development. The scar in brief was in all respects normal. At my request, she brought me her infant, two months after her confinement, the child being to all appearances entirely healthy.

The second case is that of a woman, æt. 46, having wealth, refinement, and social position, circumstances which furnished both the incentive and opportunity for paying especial attention to the care of her scalp. She had been childless throughout her married life of twenty-six years, during which time she stated that she had always enjoyed fair health. Her husband happened to have consulted me five years before for a blennorrhagic affection, followed by severe rheumatoid symptoms which had prostrated him for three months. Both parties presented themselves to me in January of the present year, the wife complaining of a growth upon the scalp, which, she stated, had annoyed her by its presence from a period which even antedated her marriage. It was chiefly noticed, she said, when the comb was passed through the hairs of her scalp; the excrescence, which was sensitive, being thus occasionally made to bleed. About one week before the date of this examination of the patient, she had been feeling ill, and had summoned her maid to dress her hair. The latter, forgetful or ignorant of the presence of this growth upon the scalp, had brought the comb into rude contact with it, the injury being followed by unusual tenderness and soreness, and slight enlargement.

When examined, the patient was seen to be a woman of full development and fair vigor, with a clear complexion and an abundant growth of soft, brown hair over a particularly clean and healthy-looking scalp. In the median line, about two inches posterior to the vertex, was a walnut-sized verrucous vegetation, distinctly pedunculated and lobulated. Three separate warty growths were determined in its mass, the surface being covered by a scanty secretion which was free from odor, doubtless in consequence of the precautions which she had taken in the care of the scalp. When the tumor was perfectly cleansed of this secretion, its surface was seen to be of a reddish tinge, evenly rounded, and covered with a thin pellicle resembling new-formed epidermis. Like the growth previously described, its pedicle or stalk could be recognized by the probe passed beneath the vegetation, though the latter could not be displaced by the fingers to an extent which could make its attachment visible. The same instrument passed between the several lobulations recognized their union upon a common base.

This papillomatous growth was completely destroyed by the Paquelin knife. When the resulting crust exfoliated, a simple granulating surface was left, which cicatrized after a few pencillings with the nitrate of silver crayon. The scar was in all respects simple, and free from any keloid-like elevation of its surface or the formation of any tufts or bunches of hairs.

These two cases seem to me to furnish types of what dermatologists would generally consent to designate by the term "papilloma." In several points they lack the distinguishing characteristics of dermatitis papillaris capillitii, notably in the absence of a history of origin from isolated vesicles, pustules, or papules, and the failure of production of more or less permanent scar-like sclerotic masses in the scalp. As already stated, these may be regarded as instances of the verrucous type of papilloma. It is true that in each case there is a history of venereal antecedents on the part of the husband, but the absence of all evidence

of such disease in both parties is sufficient to cast doubt upon any supposed symptomatic character which the lesions might possess.

Reverting now to the subject of this paper, dermatitis papillaris capillitii, its general symptomatology, as illustrated by the various cases cited, may be determined with some exactness. In view of the statements made by Prof. Kaposi at the late meeting of the International Medical Congress of London, it seems reasonable to assume that the cases first cited were all manifestations of a single disease.

Dermatitis papillaris capillitii observes in its evolution two tolerably well-defined stages: the first, exudative; the second, characterized by the formation of keloid-like elevations of the surface.

The first, or exudative, stage of the disease is characterized by the occurrence of pin-head-sized papules, vesicles, or vesico-pustules which may be either pilary or peri-pilary in situation. They are deeply seated in the substance of the scalp, the apex of each alone presenting at the surface. Eventually they all have fluid contents of a thin mucoid character, like that discharged in the kerion variety of ringworm of the scalp. When exit is given to this fluid, its quantity will be usually found to exceed the amount which could readily be contained in that part of the lesion visible at the surface. Pressure upon such evacuated lesion will usually suffice for the extrusion of a thin venous blood in marked quantity, which often distends the scalp to the degree of producing pea- to larger-sized firm elevations of the surface. Either with or without the formation of such blood-tumor, the hairs of the affected region are found, as respects many follicles, to have been as completely removed as if by epilation, while those persisting here and there over the swelling may be gathered together in wisps or tufts.

Gradually, and by an insensible transition, the second stage of the disorder is reached. The tumors above described then constitute firm, dense, small nut- to larger-sized plaques, often of the color of the unaltered scalp, either destitute of hairs or here and there covered with filaments in tufts, wisps, or bunches. These are firm in their follicles, generally of the lanugo type, neither friable in texture nor distorted in development, and never represented by stumps or broken hairs. No parasite can be recognized as present either in their follicles or shafts. The contour of these lesions is irregular, being usually indistinctly roundish, ovalish, squarish, or in a combination of these forms, seldom sending out prolongations in the manner of cicatricial keloid. In number, these developments are relatively few, rarely more than three or four occurring at the same time upon the scalp of one individual. When such lesions concur, one or more may be found in the early, and, simultaneously, others in the late stage of the disorder. The region involved

by preference is the occiput, especially the vertex, and the border of the scalp next to the nucha.

As complications of the process, usually occurring in the period between the exudative and final stages of the malady, the plaques or flattened tubercles may be covered thinly with a sebaceous secretion resembling that furnished in *seborrhœa sicca*, or may, on the contrary, become the seat of luxuriant verrucous growths, vegetations which may be described as papillomatous, offensively secreting, crust-covered, hemorrhagic, or the seat of abscesses. These also may be succeeded by the dense keloid-like growth which is observed when such verrucous vegetations have not appeared.

This much determined as to the clinical features of the disease, it can scarcely be concluded that its pathology has yet been exhaustively studied. I desire to speak with due reserve on this point, first, because I have not had the opportunity of examining sections of an invaded scalp. Second, because Kaposi has done this, giving a drawing of the phenomena recognized by him under the microscope. Third, because the discussions at the International Medical Congress at London revealed the fact that upon this point there was a wide divergence of opinion among the distinguished observers who took part in the discussion. It will be remembered that the cases presented were pronounced by Kaposi to be illustrative of the *dermatitis papillaris capillitii* described by himself. Sangster, for example, inclined to the view that the case of his patient was one of a sarcomatous nature; while Thin believed that it should be assigned to the category of the epitheliomata, that particular variety of carcinoma which the English are fond of calling rodent ulcer; while Hillairet regarded the disease as a papilloma of traumatic origin. It occurs to me that still another opinion might be formed by those critically examining the collated facts. The disease, as it is described by its several observers, might thus be regarded as a composite of several disorders. In one case, it might, for example, be assumed that a true keloid had supervened upon a simple pustular disease of the scalp; in another, that such pustular disease had resulted in the development of a papilloma of ordinary type, etc. To such objection, a sufficient answer ought certainly to be found in the definiteness with which has been established a recognizable community in the general though varying features displayed in all the reported cases. These should be sufficient to stamp the affection with an identity of its own. Moreover, spontaneous and cicatricial keloid, though apt to develop upon the nucha, and in the lobule of the ear pierced for earrings, has not been recognized as of frequent occurrence upon the scalp. How many sebaceous tumors are annually removed from this region with the knife? How often is it

incised, contused, and otherwise wounded, without the production of such accidents in the resulting scar?

I am not aware that an attempt has been made to explain the limitation of the disease to the particular part of the scalp where its lesions appear. Such explanations are indeed, it is needless to remark, often beyond our reach. Why, for example, does spontaneous keloid so often affect the pre-sternal region? Why do the several forms of xanthoma cluster chiefly about the eyelids? These are questions not readily answered. Still it has occurred to me that it was possible to find a hint respecting the localization of dermatitis papillaris capillitii in the anatomical peculiarities of its site of election.

I cannot believe that a section involving merely the thickness of a papillomatous growth on the scalp is sufficient to explain the real nature of this curious disease. Nor am I satisfied that the title dermatitis sufficiently defines its nature. A review of the cases described above awakens the suspicion that the disorder had a deeper origin than in the skin of the scalp. The earliest lesion displayed in the first case resembled those deeper pustules or circumscribed abscesses which involve the subcutaneous tissues, whose apex alone reaches the skin, but whose subsequent career may lead to definite changes which might be described as strictly cutaneous. We have all seen illustrations of this process. An abscess of the prostate gland may first appear at the level of an apparently unaltered perineum as a distinctly circumscribed pustule.

An inflammatory focus, situated between the scalp and the pericranium, would more accurately explain the earliest cutaneous symptoms in these cases than would a mere dermatitis; for it will be remembered that the evacuated contents of these lesions were, in each case, considerably greater in amount than could be accounted for by the existence merely of a cutaneous pustule. Even had such pre-existing pustule strictly cutaneous limits, its behavior certainly indicated that its floor and base had subcutaneous connections which must be regarded as important. Moreover, these lesions did not contain the fluid found within the pustules of many other suppurative disorders of the scalp, but had the peculiar contents which recalled the secretion discharged in the kerion of Celsus. I am therefore inclined to believe that for the determination of the precise nature of this malady, a section should be made, extending deeply through the scalp and subcutaneous tissues as far as the pericranium, the procurement of which, from the living body, would, in view of the benign nature of the disease, and the tendency of wounds of this region to take on erysipelatous complications, be scarcely justifiable.

The marked tendency of the punctured lesions to discharge freely a thin venous blood when subjected to even moderate pressure is not with-

out significance in this connection, especially when it is remembered that the blood-filled tumor seen by me to originate in this way may be regarded as the predecessor of the sclerotic, papillomatous, or keloid-like growth which follows. We know that the venous supply of this part of the body is very abundant, and that its channels connect, below the calvarium, with the great venous sinus which traverses the long diameter of the area chiefly involved in the disease. Here, the torcular Herophili receives the income of seven of these great venous conduits. With this, the veins of the diploë are in intimate connection, and the latter, more superficially, with the vascular distribution in the connective tissue disposed between the dense pericranium and the thick scalp. A focus of inflammation in this scalp aponeurosis finds itself limited on the one side by the dense fibrous and osseous tissues of the skull-cap, traversed at the line of the sutures by apertures for vascular ingress and egress, and on the other, by the thick mass composed of the scalp tissues. The direction of least resistance is upward, in the line of the hair follicles, and obliquely, the direction in which, as Warren, of Boston, has well shown, the pus of an anthrax leaks to the surface through the fat-columns or channels first described by him. Every surgeon suspects a connection with this aponeurosis when a scalp tumor of doubtful character is found to have deep attachments.

It seems to me reasonable to believe that these deeper tissues play some part in the production of this disease. Wherever beginning, whether in the pilary, peri-pilary, or sub-pilary tissues, and whether in the scalp proper or in the connective tissue beneath it, the characteristic product of this inflammation finds its way to the surface either through or near a hair-follicle, then establishes a connection with the deeper tissues, and eventually, either by traumatism or as a result of inflammatory weakening of the walls of the veins in the affected part, results in the effusion of venous blood. Kaposi's sketch exhibits largely dilated blood-vessels in the tumor examined by him, vessels abundantly capable of explaining the bleedings, to which he also calls attention.

The resulting blood-filled tumor forms, I am confident, the keloid-like tubercle or flat papilloma, which develops subsequently. It undergoes a species of organization, due to the peculiar vascularity of the region as already explained.

The behavior of the hairs upon a developed tumor is explainable as a natural result of the induration and subsequent contraction of the follicular and peri-follicular sclerosis. The hairs appear to fall in consequence of a process of starvation, the interposition of the blood-mass cutting off the vascular supply of the hair-pouch, while the filaments which happen to remain are, as a result of the progressive sclerosis, caught together in wisps or tufts.

With regard to the etiology of the disease, it appears to be an idiopathic affection, occurring in individuals who otherwise exhibit the evidences of fair health, irrespective of sex. The patients have been either children or adults of middle age. The essential causes of the disease are unknown, and its prognosis uncertain.

The disorder is to be evidently distinguished from all the diseases of the scalp induced by vegetable parasites, from sebaceous, fatty, and malignant tumors involving the same region, and in its earlier periods from the simple exudative affections of the scalp. As yet, too little has been accomplished in the way of treatment to establish a satisfactory basis for its therapeutic management. The French dermatologists report some cases which have been relieved by erosion of the scalp tumors.

Society Transactions.

NEW YORK DERMATOLOGICAL SOCIETY.

130TH REGULAR MEETING, OCT. 24, 1882.

DR. E. B. BRONSON, *President, in the chair.*

PRESENTATION OF CASES.

DR. BULKLEY exhibited a case of

LUPUS ERYTHEMATOSUS.

His object in presenting the case was to show the improvement that had taken place under the long-continued use of Thompson's solution of phosphorus, which she had been taking for six years without harmful effects, although she had sometimes taken as high as twenty-five drops three times a day. She had had no local treatment other than palliative, in the shape of calamine lotions, etc. The disease is now almost cured, the only active lesion being one behind the left ear, in the shape of a long, red, flat crescentic patch, and a small scaly spot on the vertex. The disease has lasted in all nine years, and numerous scars are seen along the roots of the hair on the forehead and cheeks, which are, however, pale, and but slightly disfiguring. Slight thickening of the skin on the nose still remains.

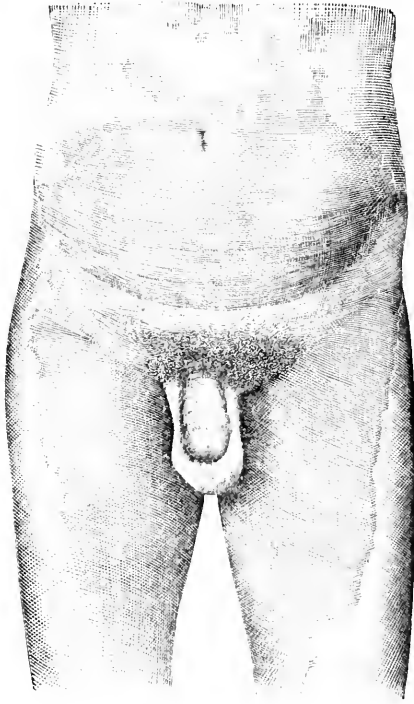
DR. PIFFARD said that the result of treatment in this case of lupus erythematosus was admirable, except for the length of time it took to accomplish it. He thought that the recovery might have been much hastened by a resort to some of the operative procedures in vogue. The doses of phosphorus which had been given seemed to him excessive, if the preparation used was an active one. He considered Thompson's solution an unreliable one, and thought the best preparations in the market were the solution in oil and some of the coated pills.

DR. BULKLEY said that he rarely used phosphorus, on account of its great liability to interfere with digestion. He felt certain that the patient under discussion had used an active preparation, since he always ordered only $\frac{3}{4}$ i. at a time, and the bottle always had a strong odor of phosphorus.

DR. PIFFARD exhibited a case of

ECZEMA MARGINATUM.

The patient was a man, twenty-three years of age, giving the following history: An eruption appeared in 1872, just back of the right ear. This presented an eczematous aspect, and lasted about three months. A short time after its disappearance an eruption appeared in the scrotum in the form of white scales, which being scratched off, a watery serum oozed out, and the skin became inflamed. This fluid would dry and form thin scales. It kept on extending up over the scrotum, around the penis and down the inside of the thighs, spreading in the form of rings, these running together and forming patches. The itching is so terrible at times that the scratching is kept up until blood oozes out. The patient



first came under observation September 19, 1882, at which time the lesion was found to be marginate in appearance and eczematous in character, occupying the situations indicated in the illustration.

The diagnosis was a long-existing trichophytosis, leading through the local irritation which it excited to the development of eczema. He believed that the parasite had probably died out some time before. For three weeks the patient was treated with *Viola tricolor* internally, and an ointment composed of

R Extr. stramonii recentis fluidi.....	3 i.
Ung. hydrarg. ammon.....	3 i.
M. ft. unguent.	

Improvement rapidly ensued, but as a few furuncles appeared, the viola was discontinued, and calx sulphurata used. The patient was now practically well, except slight infiltration of the scrotum.

DR. SHERWELL stated that he had just succeeded in completely curing a similar case, which had been under the care of a number of eminent dermatologists abroad, with but little benefit. The patient recovered entirely in two or three weeks, under a soothing line of treatment, sedative lotions, Startin's tonic mixture internally, etc.

DR. FOX thought that soothing treatment would not have cured the case shown to-night, the persistence of the disease being due to the growth of a fungus. He had found the local use of sulphurous acid, as recommended by Dr. Bulkley, both soothing and curative. Tar had always seemed to him to aggravate the disease.

DR. KEYES presented a

CASE FOR DIAGNOSIS.

The patient, a man, twenty-two years of age, presented an eruption of minute aggregated pigmented papillæ, in patches upon the lower extremities and on the backs of the hands. Each patch begins as a round, flat, smooth pigmented area, which afterwards becomes elevated. The eruption first appeared two years ago, and has persisted up to the present time, in spite of iodine, arsenic, mercury, and cod-liver oil.

DRS. BULKLEY, ROBINSON, and BRONSON considered it a case of lichen planus.

DR. FOX agreed in this diagnosis, and thinks that typical papules will develop later, on the hands. The localization of the lesions, the itching and the pigmentation, all speak for this diagnosis. The case is not a typical one, but presents the disease in a peculiar phase, which is not described in the books, but should be carefully studied. He thought that the ordinary "mixed treatment" might be of benefit, not, of course, because he supposed that the case had anything to do with syphilis, but because he had found that the mixed treatment often did good in chronic skin diseases.

DR. TAYLOR said that the superficiality, pigmentation, cicatrization, and itching of the disease, and the fact that it is follicular in origin, lead him to believe it lichen planus.

DR. KEYES stated that he had seen three cases similar to this, none of which got well under general treatment. The appearance of the lesions in the present case, its tendency to spread, and its not yielding to treatment are points in which it differs from lichen planus. He thought the disease was of a neurotic origin, the patient having mydriasis. In answer to a request for suggestions as to treatment, Dr. Bulkley said that he would like to see chrysophanic acid tried.

DR. ALEXANDER exhibited a case of

FACIAL HYPERPLASIA CUTIS.

The patient, a woman forty-five years old, a native of Ireland, came to this country at the age of eight, and had resided here ever since. She had never lived in tropical climates. In infancy she had cervical adenitis, which was followed by swelling of the face. This became quite marked at the age of two years, and has persisted up to the present time. At the age of sixteen she had an attack of small-pox, which has left numerous cicatrices. Both legs are œdematous, and have been more or less so for eight or nine years. The veins of the legs are slightly varicose. At the present time the face is greatly disfigured, the lips being enormously thickened, everted and lobulated, the cheeks and chin much thickened and dependent, as shown below.

The nose is much broader than natural, and is sunken to a certain extent between the projecting cheeks. The buccal mucous membrane is thickened and

thrown into folds, the tongue seeming comparatively normal. The eyes are almost closed, and the patient suffers from ectropium of the left lids, which has caused ulceration of the cornea, for which she has long been under treatment. The disease is confined to the face, the neck and body being free from it. In the neck, under the angles of the jaw, are a number of hyperplastic cicatrices, evidently the result of antecedent strumous ulcerations.



DR. FOX had never seen a case like this, except in one instance, of a girl of whom he had a photograph. He would not like to say whether or not it was elephantiasis, but he thought that it was dependent upon scrofula.

DR. KEYES spoke of an old nurse who had a similar affection in the lips, chin, and cheeks. That case he had called hypertrophy, and not elephantiasis, and regarded the disease as the result of stoppage of the lymphatic circulation resulting in hypernutrition of the tissues.

DR. TAYLOR had reported several years ago a case of chronic hypertrophy of the lips. He regarded this case as an instance of the same disease.

DR. PIFFARD thought it a case of chronic strumous infiltration of the tissues of the face, or hyperplasia due to pressure upon some of the efferent lymphatics. He would not liken the disease to elephantiasis, which is a specific disease, as much as leprosy. In elephantiasis we have recurrent febrile attacks, œdema of the legs, increased color, almost erysipelas in fact, which attacks leave behind an infiltrated, thickened condition of the skin, which never returns to the normal standard. In this case there has probably been an attack of inflammation of the glands, which has led to the permanent occlusion of the lymphatics.

DR. ROBINSON considered the case one of chronic hyperplasia of the corium and subcutaneous tissues, due, perhaps, to blocking up of lymphatics, with subsequent exudation.

DR. BULKLEY exhibited a

CASE FOR DIAGNOSIS.

The patient, a man aged twenty-eight years, says that he has had the eruption since he was two years of age. His father has had a similar eruption all his life.

He has two brothers and three sisters. His brothers are similarly affected, but the sisters are free from eruption. He has two children who are free from eruption.

In childhood the patient had an impetiginous eruption of the scalp. September 23, 1883, his entire body is covered with a papular and bullous eruption, with the exception mentioned below. The back and the flexor aspects of the arms and forearms, from the insertion of the deltoid to the ends of the fingers, are covered with a lichenoid eruption, and in some places there are infiltrated patches, especially on the forearms and backs of the hands. The loins and buttocks are thickly covered with papules, and the thighs are covered with bleb-like pustules with thin coverings and reddened bases, and with the torn remains of bullæ. On the legs and feet, which are most extensively effected, the lesions are very large. In some places the bullæ are from one-half to three-quarter inch in diameter. On the feet in many instances, the bullæ are purulent, and where the summits are torn off, a thickened base remains. There are numerous scars scattered over the body, more especially about the chest and middle line of the body. The scars are everywhere superficial. The axillæ, flexor aspects of the elbows, palms of hands, popliteal spaces and soles of the feet are spared. The eruption itches very greatly, as is shown by the evident signs of scratching. The lymphatics in the groin, both upper and lower groups, are enlarged. The patient had been treated by alkaline diuretics and large doses of arsenic, and a tarry ointment, under which improvement followed, until he took twenty drops of Fowler's solution ter in die, when the dose was reduced in consequence of gastro-intestinal disturbance. The improvement still continues, the bullæ having ceased to appear. Most of the lesions are papules and remain such, leaving scars after them.

DR. FOX exhibited a case of

PAINFUL PURPURIC PAPULE,

situated upon the middle of the posterior aspect of the left upper arm, where it had been for a number of years. No history of traumatism was given. The lesion could not be felt on rubbing the finger over the skin, but a minute induration could be appreciated on making light pressure downwards, which pressure gave rise to intense pain. The lesion was of a bluish color, and the skin around it was normal.

DR. PIFFARD recommended excision of the papule, which advice was generally acquiesced in, DR. BULKLEY suggesting that the papule, after excision, be examined for a foreign body.

DR. ROBINSON exhibited a case of

MORPHEA.

The patient had been first presented at a meeting of the Society, two years ago. He was now ten years old. The morpheic infiltration which had previously existed had entirely disappeared, leaving an atrophied condition of the subcutaneous tissue at the site of the original lesion.

DR. ROBINSON also exhibited the case of

SCLEREMA NEONATORUM.

which had been presented at the last meeting, in order that the members might have the opportunity to see the improvement that had taken place.

Reviews.

ESSENTIALS OF VACCINATION. By W. A. HARDAWAY, M.D., Professor of Diseases of the Skin in the Post-Graduate Faculty of the Missouri Medical College. Chicago: Jansen, McClurg & Co., 1882, pp. 146.

THE scope of this capital little handbook will be best appreciated by a glance at its table of contents, where we find chapters on the History of Vaccination—Variola in Animals—Nature of Vaccinia—Vaccinia in the Human Subject—Abnormal Modifications and Complications of Vaccinia—Revaccination—Merits of Different Kinds of Vaccine Virus—Methods of Obtaining and Storing Vaccine Virus—The Operation of Vaccinating, and an Examination of the Objections to Vaccination.

These matters are all briefly but justly considered, and the author's conclusions appear to be sound. In the absence of any thorough and exhaustive work on the subject, we can only regret that the present author has not more amply filled a gap that exists in the English literature of the subject.

SOME PRACTICAL OBSERVATIONS ON VACCINATION. By W. H. WHITEWAY WILKINSON, L.R.C.P. Ed. London: J. & A. Churchill, 1882, pp. 40.

THIS is a minor contribution to the subject, and the author bases his conclusions on his experience as a public vaccinator. Some of these conclusions are curious. He says that: "In some cases, out of four or five scratch cuts, one or two only may take, . . . you should vaccinate again, . . . in two more places." This, we believe, is entirely unnecessary. It is certainly contrary to the current practice in this country. If a single point of vaccination has "taken," as evidenced by the characteristic vesicle, it is sufficient proof that systemic infection has occurred, and that the necessary protection is afforded. Speaking of animal vaccination, he says: "Lately, it has become amongst some a fashion to vaccinate with lymph from vesicles formed upon calves. I have done but very little in this department, but remembering that the primary vaccinia took its origin in a totally different manner, I shall await the time until the protective value of this lymph is more fully developed, and rely now upon a system which is known to be valuable, and which risks a minimum of evil if carefully and conscientiously carried out." We confess that we are not quite certain that we understand the author's meaning, unless it is that bovine virus is less protective than humanized, and more likely to be attended with evil consequences—conclusions that, we think, he would hardly have arrived at if he had carefully studied the results of American experience.

TREATMENT OF THE SQUAMOUS SYPHILIDE.

DR. GOURGUES states that he has lately treated successfully two cases of this lesion with a weak solution of the acid nitrate of mercury (one part to two hundred of distilled water) used topically. The application, which was made three times in one case and four times in the other, at intervals of three or four days, merely reddened the affected parts, and gave rise to a slight irritation, which disappeared in a week, together with all the traces of the psoriasis. No internal treatment was employed during the continuance of the eruption.—*Journ. de Médecine*, August 26, 1882.

Selections.

VARIETY AND DIFFERENTIAL DIAGNOSIS OF VENEREAL SORES.

As the result of recent research in this country and abroad, and from individual observation, it would appear that two distinct classes of venereal sores exist—namely, first, those that are accompanied with and followed by constitutional symptoms; and, secondly, those that are not. The former have been designated hard or specific, and the latter soft or non-specific. It is, I think, a pity that these terms should have gained such universal acceptance, as they are not only partly erroneous, but liable to lead the inexperienced into much difficulty, and not unfrequently into errors of diagnosis and prognosis. It would be preferable (in the absence of less misleading names), to use the simple and intelligible terms, syphilitic and non-syphilitic, according as the local lesion with its accompanying symptoms presents the characters of a sore from which the constitution will become affected with syphilis or otherwise. As to the duality of the poison, we meet with many eminent surgeons who distinctly affirm that there is but one venereal poison capable of producing venereal sores, and that all such sores are syphilitic. That the constitution does escape contamination in certain cases is ascribed to the early treatment and administration of mercury, etc.

There was a time when the physician drew no line of demarcation between typhus and typhoid fever, but at the present day there are few who will doubt that the one is as distinct from the other as variola is from varicella. Nor do we now believe that the poison of typhus can produce typhoid, or that of variola varicella. Each is perfectly distinct, has its own period of incubation, its own peculiar symptoms, and individual specific poison. By an analogous mode of reasoning, drawn from the result of practical observation and inquiry, we are, I think, rationally bound to admit that two distinct classes of venereal sores exist, that each has its own peculiar period of incubation, its own symptoms, and its own specific poison. Is the poison, we may ask, which produces a syphilitic sore and infects the system with syphilis, capable of microscopic examination or chemical analysis, and, if so, does any perceptible organic difference exist between it and the peculiar specific poison which can only produce a mere local ulcer or ulcers, and which, as such, are never followed by constitutional symptoms? No solution to the above problem has, as yet, been satisfactorily determined.

In describing the local lesion or primary syphilitic sore which is always followed by constitutional symptoms, I have usually seen the following three varieties:

1. *A sore or sores characterized by induration or hardness from the beginning and throughout its entire course.* This first variety may appear as (a) a "cupped-shaped" cartilaginous cavity of variable size, and situated on an indurated base, or (b) it may be seen as a superficial excoriation or elevated elliptical nodule of an ash-gray or livid color, and generally situated on the corona glandis. Sometimes this first variety appears as (c) an induration beneath the true skin.

2. The second variety (*soft in its early stage, but subsequently becoming indurated*) is seen as a sore or sores which in their early stage simulate the non-syphilitic ulcer or ulcers, but subsequently become indurated and followed by constitutional symptoms. It is exceedingly difficult to diagnosticate this second variety in its early stage, as I believe it is invariably complicated by the existence of non-syphilitic sores, one or more of which after a variable time may assume the characters of the true syphilitic ulcer or ulcers. The question may arise as to how this peculiar change in the non-syphilitic ulcer takes place, and an explanation be called for. I believe it is due to the existence of a double poison manifesting itself in the one individual, contracted either at the same time (as we know that both classes of venereal sore may exist in the same person) or at different intervals. The period of incubation of non-syphilitic sores being much shorter than that of the syphilitic, they first appear, and whilst being treated, the incubative stage of the true syphilitic sore is accomplished, and the lesion becomes manifest. The last case which came under my observation of this second variety of syphilitic sore is worthy of record, as it clearly illustrates the difficulty that attends our early diagnosis.

A corporal in the 4th Dragoon Guards was admitted to hospital under my care suffering from what appeared to be two ordinary non-syphilitic ulcers, situated on the upper surface of the glans immediately in front of the corona. The ulcers were shallow, and had all the characters of the so-called "soft-sores." After three weeks from admission to hospital, both ulcers became elevated and livid, and presented the appearance of "cupped-shaped" cartilaginous cavities situated on indurated bases; subsequently unmistakable secondary symptoms followed.

3. The third variety of syphilitic sore—namely, *that which is soft from the beginning and throughout its entire course, but followed at a given period by secondary symptoms*—I have usually seen on the external integument situated on the dorsum or side of the penis. When this sore comes under our observation, it is generally of two or three days' duration, is circular in form, about the size of a sixpence, edges irregular and sharp, surface presenting a finely granular appearance of a yellow-pink color, and having a thin ichorous discharge. There is no induration accompanying this sore, either in its early stage or after it has healed, and it is invariably followed by constitutional symptoms. Again, it is our lot to see a sore situated probably on the side of the corona and glans, which rapidly spreads in circumference and depth; the edges seemingly raised, the surface deep and irregular, of a dark or livid color, and discharging a thin watery fluid. I have been unable to detect any induration about this sore, and have seen it followed by severe secondary symptoms.

Having described and attempted a classification of those ulcers and lesions which I have seen followed by constitutional symptoms, I shall endeavor to point out the non-syphilitic sores which, as such, are never followed by secondary symptoms.

1. A sore or sores, having a great tendency to multiply, often numbering as many as twenty, and generally situated in the hollow between the glans and the prepuce, on the corona glandis, prepuce, frænum, glans, in the meatus, urethra, or on the external skin. These ulcers are first noticed from twenty-four to forty-eight hours after coitus; in some cases, however, they may not appear until the fourth or fifth day. There is generally a good deal of heat and itching about the parts, the ulcers as a rule, being round or elliptical in shape, and of variable size, very shallow, edges sharp, surface yellowish-pink color, discharging pus, and surrounded by a narrow red areola. There is no induration from the begin-

ning or throughout the entire course of these ulcers, unless, as sometimes happens, induration occurs as the result of certain local applications.

2. A sloughing sore, which may begin as such, or appear so shortly after the ordinary sores are discovered.

3. Gangrenous ulceration or sloughing phagedæna is, fortunately, of rare occurrence; when it does take place, the greater portion of the organ may be destroyed. It would appear that an elongated prepuce predisposes to this formidable affection, the upper portion of which first becomes affected. It is, I think, well to give a very guarded prognosis in all cases of sloughing or phagedænic sores. The ordinary non-syphilitic ulcers must not be confounded with herpes or aphthæ of the glands and prepuce, or with what sometimes occurs, a ruptured frænum, the result of mechanical violence. These, as a rule, occur after connection, have no specific characters, and are unaccompanied by glandular or other complications.

The following table, giving the differential diagnosis between syphilitic and non-syphilitic ulcers, may be useful in helping to form an early and correct opinion of venereal sores.

Syphilitic Ulcers or Lesions.

1. Incubation ten days to eight weeks.
2. Collateral symptoms: Probable congestion of soft palate and tonsils, slight induration of lymphatic glands in groin, drowsiness, headache, and depression of spirits.
3. Primary lesion or lesions assume some of the varieties described under Class I.
4. Thin ichorous discharge.
5. Generally single.
6. Glands in groin enlarge, but seldom suppurate.
7. Fever present after a short time.
8. Ratio to non-syphilitic ulcers 1:4.
9. Constitutional symptoms invariably follow.
10. Can only have one attack, unless, as in certain rare cases of small-pox, the system, after the lapse of many years, becomes liable to a second seizure.
11. Prognosis unfavorable; must be guarded, and given in accordance with the severity, or otherwise, of the secondary symptoms.

Non-syphilitic Ulcers.

1. Incubation twenty-four hours to five days.
2. Collateral symptoms: Probable enlargement and swelling of one lymphatic gland in groin.
3. Ulcer or ulcers assume the characters described under Class II.
4. Discharge always pus.
5. Seldom seen as a single ulcer, and have great tendency to multiply.
6. An isolated gland becomes swollen, and frequently suppurates.
7. Fever absent, unless due to suppuration.
8. Ratio to syphilitic ulcers 4:1.
9. Constitutional symptoms never follow.
10. May suffer repeatedly from such sores.
11. Prognosis (as to the liability of the system becoming affected) always favorable.

—BATTERSBY, *Lancet*, September 2, 1882.

A NEW URETHRAL SYRINGE.

The defects of the common glass syringe, with its thread-enwound piston and slippery knob, and, in less degree, of the improved instruments devised by Sir Henry Thompson and Mr. Berkeley Hill, are well-known to all who have had occasion to use them. Mr. Squire sets forth as follows the requisites for a perfect appliance of the kind:

It should admit of being held and operated by one hand only.

It should do its work completely, and at once.

It should act easily and smoothly, should be strong, and not liable to derangement.

Its nozzle should not be subject to jerks or displacement from the operation of the piston.

It should send no part of the injection into the bladder, nor any air into the urethra.

It should be of such size and shape as to be conveniently and safely carried in the waistcoat pocket when filled in readiness for use.

The contrivance by which he claims to have fulfilled the second conditions consists of a fluid-holder of vulcanized rubber terminating in a tube, also of rubber, to which a glass nozzle is attached. The holder is elliptical in shape, with flattened sides, each of which is rendered quite stiff by the insertion of a thin plate of iron. The wall of connection around the edges of these, being composed of rubber, is elastic, and it bulges out a little, so that the two rigid sides, when pressed together, are brought into the closest possible contact.



If, now, the sides be thus compressed, and the nozzle of the syringe be placed in water, a certain definite quantity of the fluid will at once be drawn up; and if, in the next place, the compression be repeated, exactly the same quantity will be expelled, but without a single bubble of air. The capacity of the syringe is such that this quantity is precisely that which will fill the urethra without excessively distending it—*i. e.*, according to the author, one drachm and a half of fluid.

The nozzle is fitted with a movable rubber cap, so that a syringe filled with the injection may be securely carried in the pocket.



To guard against the possibility of corrosion, the laminae of iron used as stiffeners are rubber-coated on both their surfaces; and the glass nozzle is provided with a circular ridge or shoulder-piece, to keep it from slipping into the urethra in case it should happen to become detached from the rubber tube; or, as an additional precaution, the latter can be drawn over the projection. But if the instrument be properly made, no such danger need be apprehended.—SQUIRE, *Ann. de Derm. et de Syph.*, April, 1882.

TREATMENT OF ECZEMA MARGINATUM.

DR. THOS. F. WOOD recommends in this affection the use of iodized phenol, prepared by mixing one part of iodine with two parts of carbolic acid. He writes as follows:

Success in the treatment of eczema marginatum with iodized phenol will depend upon the way in which it is employed. In some cases the full strength of the preparation cauterizes severely, and in others it causes almost unbearable pain. The majority of patients will be able to stand the application full strength, but if by chance you get a patient whose first experience is painful, it will not be so easy to induce him to continue the treatment.

The complete eradication of the disease requires long and patient treatment, although the first few applications afford so much relief from the itching, that, as soon as desquamation takes place and the clean surface appears, the patient is apt to neglect treatment, and return to you after many weeks with a reappearance of a group of itching red "buttons," as Dr. Fox terms them.

To apply the iodized phenol properly, the patient should have a preliminary bath. A piece of absorbent cotton, twisted over the end of a match, makes a good applicator. The fluid should be applied experimentally over two or three of the marginal patches or buttons, to determine the patient's tolerance of the stronger fluid. If no severe pains result after waiting a few minutes, the application may be made over all the *margin* of the eruption. This should be repeated daily until desquamation commences. Desquamation, of course, leaves the skin very tender, and consequently applications should then be made only to the red "buttons" as they show themselves. The last to disappear will be those well up to the verge of the anus, but daily all of them should be diligently sought for, and touched with the fluid.

In cases intolerant of the full strength fluid, it can be applied diluted with equal parts of glycerin. It usually takes a longer time to relieve a patient with the mitigated solution.

Very few cases can be left to the patient to treat, for, if one or two patches escape his eye, it will serve as a focus of contagion, which will eventually become as bad as ever.—*North Carolina Med. Journ.*, October, 1882.

MULTIPLE AND CONGENITAL FIBROMATA MOLLUSCA.

The patient was covered with tumors, large and small, to the number of about 3,000. One of them, whose ulcerations was the cause of her death, occupied the clavicular region as far as beneath the left axilla, and was as large as the head of an adult.

Microscopic examination showed these growths to be composed principally of connective tissue, both old and of recent formation:—they were fuso-cellular sarcomata.

The autopsy revealed a large number of these tumors seated on the nerve-trunks and their ramifications (the sub-orbital, facial, pneumogastric: nerves of the arm, lumbar plexus, etc.).

The author adheres to the theory of Recklinghausen, which regards molluscos fibromata as true neuro-fibromata, being first developed on the nerve-trunk itself, and then spreading to the filaments proceeding from the latter.—MODRZEJEWSKI, *Gaz. Hebdom.*, August 4, 1882.



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CASE OF PIGMENTED NEOPLASM OF THE SKIN.¹

BY

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E. S., æt. 40, resides at Kansas City, Mo. Occupation, merchant. His father died of pneumonia at the age of seventy-five, and his mother, of cholera in 1849, in her fiftieth year. Three sisters are living quite advanced in years. His only two brothers died some time since, one at fifty, and the other about thirty-seven years. There is no history of skin disease of any kind in the family. The patient has been told that in early childhood he suffered from convulsions, but within his own recollection he has never been seriously ill. Mr. S. was a pilot on the Mississippi River for six or seven years, but retired from that calling in 1867. He had a mild attack of varioloid in 1868. He recalls a discharge from the ear since youth. He has had gonorrhœa twice, but has had no venereal sores of any sort. In 1871 had a cockscomb vegetation in the sulcus behind the corona glandis. About this time, according to his best recollection, glandular enlargements appeared in various situations, notably in the axillæ, on both sides of the neck, in the groins, and at the elbows. The patient is positive that neither at this time nor at any time subsequently did he have any of the well-recognized symptoms of syphilis.

In 1874, to rid himself of the enlarged glands, which, however, were

¹ Read before the American Dermatological Association at Newport, R. I., Aug. 29, 1882.

productive of neither pain nor uneasiness, he commenced to take, on his own responsibility, the iodide of potassium in combination with the syrup of sarsaparilla; but these drugs were without influence upon the swelling of the glands. After he had taken the medicines mentioned for a few months, the patient says he noticed a small number of pimples which did not "come to a head" about the region of the face. In the course of time the "soreness" of the pimples abated, but left, as he thinks, little brown discolorations in their stead. He believes that he is able to state that one of the patches, now situated at the head of the right eyebrow, and one which is now present at the junction of the left ala of the nose with the cheek, began in the small brownish spots left by the pimples referred to above. The pigmented spots increased in number, but, so far as he knew, were never initiated in the manner just described; but, on the contrary, commenced as reddish-brown maculæ, after the manner of their present evolution. The evolution of the pathological process has been very gradual. In 1876, when the eruption on the face had become quite well developed, S. consulted a physician who pronounced his disease to be syphilitic, and put him on an exceedingly active mixed treatment (mercury and iodide of potassium). He was under this medication for seven months, but at the end of that time his medical attendant concluded that he was mistaken in his diagnosis and suspended the use of the drugs, as they had made no impression either upon the cutaneous lesions or upon the enlarged glands. In 1877, the patient went to the Hot Springs of Arkansas, where he took the baths and consulted a homœopath; but also without avail. S. says that he has personally blistered and cauterized some of the patches, but thinks without altering the aspect of his malady in the least. He thinks that the general color of the eruption has not undergone any material change since the beginning. He is quite positive that the swelling of the lymphatic glands preceded the eruption for almost four years. It remains to add that the patient was married in 1878, and has two perfectly healthy children; one a boy of three years, and the other an infant of some few months.

Present condition.—The patient was first seen by me two years ago, and although I have no notes of his appearance at that time, I am confident that his disease had undergone no material change when I again examined him on the 22d of March, 1882. Since the latter date he has been constantly under observation. S. is a man of good muscular build, about five feet nine and a half inches in height, of a rather peculiar sandy complexion, and having reddish-brown hair and beard. Eyes are gray. Lungs, heart, liver, and spleen apparently normal. Bowels regular, and appetite good; does not suffer from dyspepsia. Eyesight unusually acute, but hearing somewhat defective. The patient feels in perfect physical health, except that he occasionally experiences some

giddiness when exposed to great heat. Upon examination, the lymphatic glands in the groin are found to be variously enlarged, and are from the size of a pea to that of a hazel-nut. The epitrochlear glands are quite visible to the eye. The glands in the neck are not so much enlarged as formerly, but are still notably involved. These variously situated glands are freely movable and perfectly painless. As stated above, the patient is fully satisfied that the glandular involvements anticipated the cutaneous lesions by many months; and, with the exception of the cervical glands, which he says are not now so large as in former years, he is equally confident that they have undergone no material change since the beginning—a period of about ten years. I am in a position to corroborate so much of this statement as relates to the past two years.

The patient's skin, except in the affected parts, is perfectly normal, its various functions being unimpaired. The cutaneous lesions are situated upon the forehead; upper right eyelid; on the cheeks, in among the beard; on the chin; on the front, sides, and back of the neck; upon the knees; and upon the right and left insteps. They number altogether about thirty-one. They vary in size from a split pea up to lesions at least two inches in length and an inch in width. The largest plaques are about the face and neck; the smallest pea-sized macules are on the knees and feet; but the regions first named also exhibit some of the small macules, while the feet and knees are occupied exclusively by the smallest lesions. The general shape of the lesions is ovalish; this is especially shown in the isolated plaques. The color assumed by the lesions is of two shades or varieties. Upon casual inspection, it is at once observed that the centres are of a pinkish-red color, and that the borders are decidedly orange-hued. The small macules are entirely orange-colored, the division into centre and border not having yet occurred. Upon closer observation, it is to be noted that the whole centre of a given patch, that is, in the large lesions, is traversed in all directions by blood-vessels, but curiously enough these vessels do not run into the orange-colored border, but are abruptly and invariably limited to the inner pinkish part of the lesion. The small spots have no vessels upon them. Nowhere upon the skin, except in the places mentioned, are any telangiectases to be seen. Upon the small spots the epidermis seemed slightly cracked, a sort of fraying, which is, however, barely perceptible. This same condition is, to a slight extent, observable upon the orange-colored borders of the large patches, but their centres present a smooth epidermic covering. The orange-colored borders of the lesions about the face are appreciably elevated, while their centres are depressed. As a matter of course, the small spots do not exhibit this arrangement. The large growths on the side and back of the neck are of one uniform

surface, and although they possess the peculiar border and centre, already described, in common with the other large lesions, this border is not at all elevated, nor do the centres show any evidence of atrophy. These growths rise several lines above the plane of the integument. It is noteworthy that the large lesions on the face are older than those on the neck. The orange-colored borders, where most developed, are about one-eighth inch in width.

Upon pinching up the affected skin, it is readily perceived that we are dealing with an infiltration that apparently occupies the whole thickness of the skin, but the thickest patches are freely movable and do not have a sclerosed feel, but are more or less compressible. The lesions on the forehead are undoubtedly undergoing a gradual involution, for their centres exhibit evidences of thinning. Over the right brow—perhaps the very earliest lesion—the outer elevated and pigmented ring is still well-developed, but a good portion of the centre has become almost normal in color, and there are no vessels to be seen entering this atrophic portion of the lesion. Over the left temple, in the hair, an early lesion has also undergone involution to a certain degree; the centre is much pale and thin, while the border is divided into three segments which, however, are considerably infiltrated. Where the lesions invade the region of the beard, they seem to offer no check to the growth of the hair. Perspiration does not come out as freely upon the diseased parts as upon the normal skin, yet it is not entirely deficient. The disease gives rise to no symptoms whatever, either subjective or objective. I carefully tested the patches for evidences of altered sensibility, but I could not satisfy myself that any such existed. The patient thought that, perhaps, pressure over the large lesions occasioned a moderate degree of sensitiveness. In March, there was excised for microscopical examination through the whole thickness of the skin, from one of the largest plaques on the back of the neck, a piece of tissue one-half inch long. The wound left was united by three sutures, and readily healed by the first intention.

In concluding the clinical history of this case, I wish to call attention to the following points: 1. The presence of the enlarged lymphatic glands, and the established fact that they considerably antedated the appearance of the skin affection. 2. The occurrence of the disease first upon the face, appearing only after some years upon other parts, and last of all upon the lower extremities. 3. The method of evolution of the lesions. These appeared primarily as very small orange-colored macules; in the next stage of their existence—the growths upon the neck—we perceive large uniformly elevated plaques with reddish centres traversed by blood-vessels, and having quite wide pigmented borders; after this, we find that the centres have become depressed and

thinned, though still traversed by vessels, and that the borders appear elevated; finally—the last stage—apparent involution of the centre, disappearance of blood-vessels, and segmentation of the pigmented border. Whether this will be the course of any further number of the lesions it is now impossible to say, but it seemed of sufficient interest to record.

Since the first part of this paper was written, my friend, Dr. C. Heitzmann, of New York, has kindly presented me with a report of the microscopical examination of the specimen, excised in March, which he was good enough to undertake at my request:¹

“The piece of the tumor, sent for examination by Dr. Hardaway, was about $\frac{1}{4}$ ” in diameter, and to the naked eye exhibited on the transverse section in its lowest portion, viz.: that nearest to the subcutaneous tissue, a zone, 1” wide, with dark-brown pigmentation, the rest was indistinctly dotted, but not pigmented. Under the microscope the following features were observed:

The surface is nearly smooth, supplied with unchanged hairs. The epithelial layer is considerably narrowed and consists of only three to four layers of cuboidal and one layer of columnar epithelia, without marked pigmentation. The papillae are partly unchanged, partly evened out up to their complete disappearance. The blood-vessels of the papillary layer are filled with blood.

The connective tissue of the papillary layer and the adjacent portion of the derma consists of an unchanged delicate connective tissue without the formation of interlacing bundles.

Close below the papillary layer begins the formation of the tumor in the shape of globular nests, surrounded by a comparatively coarse, fibrous connective tissue. The nests are small near the outer surface, and become the larger the nearer the subcutaneous tissue; in the latter situation they surpass in size the uppermost nests by five to six diameters. All nests are filled with medullary or embryonal corpuscles of various sizes and shapes, all being separated from each other by a delicate layer of cement-substance. The plastids are in part small, globular and homogeneous, others are coarsely granular, non-nucleated, again others are large, finely granular and distinctly nucleated. Nowhere do the plastids assume the size and polyhedral shape of epithelia. The smallest nests often contain granular bioplaxson with interspersed nuclei, so-called myeloplexy or multinuclear bodies, without a differentiation into single plastids. Smaller multinuclear bodies are also met with, together with medullary corpuscles in larger nests.

The lowest portions of the tumor, those nearest to the subcutaneous tissue, are characterized by the presence of a large amount of a dark-brown pigment. The pigment granules are mostly accumulated in the plastids within the globular nests, many of which are filled with pigment to such an extent as to represent pigment-clusters. Pigment granules and clusters are also met with in the intervening connective tissue frame, in some localities collected into larger masses.

The hair-follicles are unchanged. The subcutaneous fat-tissue exhibits the ordinary fat-globules, unchanged, while in the delicate connective

¹ The specimens were exhibited at the meeting.

tive tissue between the fat-globules scanty, in part star-shaped pigment-clusters are seen.

Tumors of this kind represent the form of what first Billroth termed *alveolar sarcoma* which I termed *alveolar myeloma*. From the description it follows, that the tumor was originally of a little malignant type, for the most superficial and evidently oldest nests are very small, and the intervening connective-tissue layer is comparatively broad. In advancing growth the tumor has gradually assumed a more malignant type, and the largest nests nearest the subcutaneous tissue being amply supplied with pigment, represent the very worst type of myeloma, *i. e.*, the structure of *melanotic alveolar myeloma*. The prognosis in such cases is known to be unfavorable."

It had been my intention to offer some remarks relating to the diagnosis, probable prognosis and other features of this case; but for the present I shall content myself with the clinical picture which I have attempted to draw, being fully assured that affections of this class are still rare enough to warrant the minutest detail in their relation.¹

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CALX SULPHURATA AND ITS USES IN CUTANEOUS AND SOME OTHER DISEASES.²

BY

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THE United States Pharmacopœia (Sixth Revision) states that this substance is "a mixture (commonly misnamed sulphide of calcium) consisting chiefly of sulphide of calcium and sulphate of calcium in varying proportions, but containing not less than thirty-six per cent of absolute sulphide of calcium." It is prepared by mixing one hundred parts of lime with ninety parts of sulphur and exposing the mixture in a closed crucible to a red heat for an hour. When cool, it is to be rubbed to powder and to be transferred at once to small glass-stoppered vials. It is described as "a grayish-white or yellowish-white powder, gradually altered by exposure to air, exhaling a faint odor of hydrosulphuric acid, having an offensive alkaline taste and an alkaline reaction. Very slightly soluble in water and insoluble in alcohol."

Calx sulphurata was known in the older pharmacy under the names of

¹ I have just seen (December 7th) the patient, and find him in excellent general health. The skin affection has undergone no change, except from the result of the treatment. The method employed was by puncture with the electrolytic needles, after the manner recommended by me in port-wine mark, and which I am also employing with good results in lupus erythematosus, and some forms of lupus vulgaris. In this case I attacked the centres of the patches only—including the telangiectases—and I discover that good, smooth cicatrices have resulted.

² Read at the meeting of the American Dermatological Association, August 30, 1882.

Sulphuretum calcis and *Hepar sulphuris calcarea*, and the homœopaths have retained this latter name for a substance substantially the same as the one under consideration. The homœopathic preparation is made from burned oyster shells instead of from pure lime, and is of still more indefinite composition than the officinal product. During the last century calx sulphurata was somewhat in vogue as a remedy for, or antidote to the effects resulting from the excessive use of mercury. When physicians began to use this drug with more discretion, the antidote was less frequently required and gradually passed out of sight. The homœopaths, however, had retained it as a remedy against suppuration and for other purposes.

About ten or twelve years ago, Ringer brought it to the notice of the regular profession as a positive and useful remedy in furuncles. His statements concerning it are familiar to many, but for sake of completeness may properly be introduced in this place. Speaking of the alkaline sulphides generally, he says: "This group of remedies influences the suppurative process in a marked and manifest manner.

"Thus, the common case of a sore, discharging a thin, watery, unhealthy ichor, will speedily undergo a healthy change under the administration of sulphide of calcium,¹ the discharge becoming at first more abundant, afterward diminishing, and throughout continuing thicker and healthier, with all the characters of 'laudable' pus." He further speaks of their property of preventing and arresting suppuration; while after the formation of pus, the influence of the sulphides is still more conspicuous, as they hasten maturation, diminish and circumscribe the inflammation, promote the passage of pus to the surface, and the evacuation of the abscess. Continuing, he says: "In boils and carbuncles these remedies yield excellent results. A tenth of a grain of sulphide of calcium, given hourly or every two or three hours, will generally prevent the formation of fresh boils, while it lessens the inflammation and reduces the area of existing boils, thus considerably curtailing the course of the boil. Where the skin is not yet broken, or the slowly separating core, therefore, not yet exposed, the sulphides often convert the boil into an abscess, so that on bursting, pus is freely discharged and the wound at once heals; or if the centre of the hardened swollen tissues is not yet dead, the pustule dries up, the inflammation subsides, and a hard knot is left which disappears in a few days without the formation of a core, and without any discharge. . . . In carbuncles the sulphides will generally be found equally serviceable, melting, as it were, the core to healthy pus and so quickly expelling the dead and otherwise slow-separating tissue."

¹ It is unfortunate that Ringer should have used this name, implying that the substance employed by him was a pure chemical compound. Pure sulphide of calcium has never been obtainable in the drug market, nor been used therapeutically.

To one familiar only with the therapeutic resources of twenty years ago, the foregoing statements of Ringer must have seemed incredible, and there is little doubt that the majority of his readers regarded them as almost unworthy of attention. It was not long, however, before confirmatory reports appeared, and there seemed to be little doubt that in calx sulphurata the profession had found a remedy for the furuncular condition that was both prompt in its action, and positive in its effects. It is true that there were many apparent failures, and that some cases seemed to be made worse instead of better. This was rather to be expected when we recollect the uncertain character of the drug itself, and the variability of its composition as met with in the market. Besides this, many physicians seem to partake of the fallacious idea that, if a certain dose of a given drug does good, a larger dose will do more good. Acting on this, and wishing to banish the boils with extra speed, they increased the dose to half a grain, one grain, two grains, and even more, instead of following the explicit directions of Ringer. The result was increase of the trouble, an event that might have been anticipated when we consider the probable physiological action of the drug. Absolutely negative results may perhaps have been due to the substitution of the sulphate or the sulphite of calcium for the drug in question; the latter mistake the writer has known to have been made. Be all this as it may, the fact seems to be thoroughly substantiated that calx sulphurata is not only a remedy of value, but probably the most valuable remedy that we at present possess in furuncular affections.

The next important claim in behalf of calx sulphurata was made by Cane,¹ who asserted that he had found it extremely useful in certain cases of acne, administering the drug in much the same manner as recommended by Ringer. Cane's assertions were tested by many subsequent observers, and general experience has proved corroborative of them. Some physicians, however, fell into the same error that is noticed above, *i. e.*, the administration of two large or too frequent doses, and as a result reported aggravation of the eruption, and even the induction of furuncular lesions.² Another common error consisted in administering it in all sorts of acne, irrespective of the variety or grade of inflammation present. It is true that the drug is capable of playing a useful rôle in most cases, but the best results are attainable only when the dose is properly adapted to the particular case in hand, and in few drugs is the range of useful doses greater than in the one under consideration. On the one hand, the $\frac{1}{100}$ of a grain once or twice a day will most quickly promote the cure, while, on the other, it is more advisable to use a full grain and repeat it with sufficient frequency to promptly provoke the physiological action of the drug. Between these extremes there are all grades

¹ Lancet, Feb., 1878, p. 215.

² Alexander, Archives of Dermat., Jan., 1882.

of cases, and the principal distinguishing feature as regards dosage is the grade of inflammation and the activity of the process. In case of acne simplex with acute pustular lesions, the smaller dose is most appropriate, and should not be too long continued, while, in sluggish papules occurring in lymphatic subjects, a tenth of a grain, a fifth, or even a half should be given with frequent repetitions, and until pustulation is imminent. When this point is reached, the drug should be discontinued. At this junction amendment usually commences. This may continue for several days and until the effect of the drug wears off. A renewal of the medicine again brings on a semblance of acuteness, and when this subsides, improvement is further manifest. Continuing in this manner, an indolent acne of several years' duration may be brought to an end, and, as a rule, in much less time than by any other method known to the writer. I usually abstain from local applications in the indolent form of acne; occasionally, however, aiding the internal treatment by dusting on a little precipitated sulphur, either pure or diluted with from one to four parts of ordinary toilet-powder. The precipitated sulphur acts as a local stimulant and irritant, and, like the calx sulphurata, should be continued for but a few days at a time, and resumed only when the artificial irritation shall have subsided.

Calx sulphurata is also capable of playing a useful part in several forms of eczema. In the impetiginous variety, whether acute or subacute, it is of value, the dosage being guided by the same rules as in the case of acne, namely, a small dose in acute and a medium dose in the subacute. In children, for instance, in the acute form I have often found the one-hundredth of a grain more serviceable than larger doses. Again, in cases of eczema rubrum of children, of the vesicular or serous variety, when accompanied with much local heat and soreness, a few of the smaller doses just mentioned have in repeated instances produced a most decided amelioration.

In eczema of the chin and cheeks of adult males, characterized by follicular pustules and nodules, the non-parasitic syecosis of many writers, calx sulphurata has displayed a promptness of action that was surprising. Cases that under the ordinary treatment by epilation and ointments would have been perhaps months in recovering, have been, by the use of this drug, cured in apparently one-fourth the time, the treatment being a matter of weeks rather than months. At the start, all hairs that perforate pustules should be extracted in order to remove sources of local irritation, and to give free egress to the pus in the follicles. The drug should then be given in doses of about one-tenth grain two or three times a day, and a sedative ointment may or may not be prescribed in addition. It rarely happens that a second epilation becomes necessary, or that treatment need be prolonged beyond four or five weeks at the far-

theft. This statement is based on the observation of a dozen or fifteen cases treated in the manner indicated. There is perhaps no one of the commoner affections of the skin in which I have been so thoroughly satisfied with the effects of internal remedial agents as in the instances just referred to.

Another form of eczema may be referred to and illustrated by a case : —A gentleman fifty years of age consulted me a few months ago, for a long standing infiltrated eczema of the lower extremities. About the ankles there was considerable thickening and nodulation, in fact, the condition described by some writers as *eczema hypertrophicum*. An investigation of the patient's general condition, rather than the local lesions, led me to prescribe calx sulphurata in doses of one-fifth of a grain. At the end of ten days there was very manifest improvement, and on the occasion of the patient's next visit, two weeks later, the change that had taken place in the lesions was surprising. His general health, too, was improved. The patient at this time informed me that his physician had found sugar in his urine before coming under my treatment, but that none was discovered at an examination a few days before. I must confess that I had not suspected the glycosuria, but the fact interested me greatly, in view of the experience of Dr. N. C. Husted, of this city, who had been a sufferer from diabetes for several years. While in this condition he became troubled with furuncles and took calx sulphurata for their relief. To his surprise the sugar disappeared, and he at the present time is apparently restored to health. Dr. Husted has since derived great benefit from the use of this drug in several other cases of diabetes.

The two following cases illustrate another phase of usefulness of calx sulphurata:

A gentleman, 55 or 60 years of age, sent for me hurriedly on Saturday morning, April 22, 1882. On arrival I learned that on awakening he had found his upper lip, or rather the right third of it, swollen and painful. At the time of my visit, the swelling had extended toward the left, and embraced nearly the whole lip. The tissues were firm and brawny, suggesting a commencing erysipelas, the infiltration involving not only the skin, but the subcutaneous tissues. The closest examination failed to detect the slightest traumatism, and the cause of the trouble was not ascertained. Calx sulphurata gr. $\frac{1}{10}$ every four hours. At my evening visit the swelling had greatly subsided, and on the following morning the part was substantially well, and further treatment was discontinued.

A week later, a gentleman about 35 years of age presented himself with a similar condition of the lower lip. No cause was discoverable, except that a small erosion or fissure of the mucous membrane at the median line was possibly the starting-point. The patient fancied that he had

poisoned himself with tobacco through this fissure. The swelling and inflammation had appeared on the preceding day. Calx sulphurata was prescribed. The following day there was decidedly less swelling, and in a few days all trace of the trouble had disappeared.¹

It is, of course, possible that these acute swellings of the lips would have subsided just as quickly if no medicine had been given. I place them on record simply on account of their rarity, and the prompt "*post hoc*" change, leaving to each reader the privilege of placing his own valuation on the "*propter hoc*."

Apropos of these cases, however, the following extract from Phillips' *Materia Medica* may prove of interest, as showing the effect of the drug in chronic swelling of the lips.—This writer says: "Scrofulous children are often disfigured by a chronic swellings of the upper lip and alae nasi, which may be connected with a crack or fissure on the inner surface of the mucous membrane. Accompanying this condition there often exists a tendency to dyspepsia, and indolent swelling of the mesenteric, cervical, and other glands.

"Although we cannot cure the constitutional tendency in such cases by sulphide of calcium, yet I have seen their general condition greatly improved by small doses ($\frac{1}{4}$ gr.) given night and morning for a few weeks; the fissure has healed, and the lip swelling subsided, and the glands have grown less."

Turning now from the *skin*, we find in the writings of others that calx sulphurata has been used successfully in certain inflammatory affections of the ears,² of the eyes,³ of the tonsils, inguinal glands,⁴ etc. In other words, its range of usefulness is not confined to purely cutaneous diseases, but it seems to have a direct influence on the inflammatory process, especially when this latter is accompanied by exudation containing formed elements (leucocytes), whether on free surfaces or within the substance of parenchymatous organs.

It has often happened that when a new drug has been brought forward as a remedy of value in a given disease, further acquaintance with it has shown it to be useful in other diseases, and its general sphere of usefulness is usually discovered in one of three ways: (1) accidentally, (2) by trying it clinically in a large number of diseases, and (3) by ascertaining its physiological action and then making careful use of it in such pathological conditions as it would seem to be indicated in.

¹ Since the foregoing was written, the patient has informed me that about two months later he had another attack of lip swelling, similar to the other, except that there was no fissure; the trouble subsided in about a week without treatment.

² SEXTON, *Am. Journ. of Otology*, January, 1879.

³ SNELL, *Practitioner*, January, 1882.

⁴ OTIS, *N. Y. Med. Journ.*, May, 1880.

The first of these methods can hardly be called scientific, the second is most frequently employed, and is the one that appears to have revealed most of the virtues of the drug we are considering. The third method, however, appears to us to be that which is most truly scientific, and the one to be employed whenever practicable. As regards calx sulphurata, we are almost without exact scientific data as to either its general or special physiological action.¹ Under these circumstances, this action can only be inferred by a close observation and study of its effects when administered in disease. My own experiences, extending over a series of years, lead me to the inference that the drug is an aplastic or resolvent of great energy; that its tendency, when given in sufficient doses, is to break down and dissolve, rather than build up and restore. This theory of its action is in perfect harmony with the observed effects of its administration; and if it be the correct explanation, it will lead us to a multitude of useful applications of the drug. In other words, it appears to me probable that calx sulphurata will be found capable of fulfilling the rôle that was assigned to mercury thirty and forty years ago, that of a general resolvent in inflammatory exudations, chronic infiltrations, and possibly also in some forms of neoplasm.

THE ETIOLOGY OF URTICARIA.

BY

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AN inquiry into the causes of urticaria opens a most interesting and fruitful field of research. No other disease of the skin possesses such a wealth of etiological factors. In no other disease is the cause at one time so manifest, and at another time so elusive. A search for this cause is often the first step towards a successful treatment of the disease, and the mystery which is so often connected with it, encourages even though it defies our investigation. While careful clinical observation has detected a number of exciting causes, there still remain many predisposing conditions which cannot be demonstrated

¹ I am perfectly aware that an extensive "proving" of this drug was made and published by Hahnemann fifty years ago, but an examination of it does not aid us much, as the writer neither gives the dose or doses employed, the frequency of their repetition, nor the sequence of the symptoms or other phenomena that followed their administration. However satisfactory it may have been to the early homœopaths, it certainly does not fulfil the scientific requirements of physicians of the present day.

with any degree of accuracy, but whose existence, nevertheless, must be assumed.

The exciting causes of urticaria consist in certain forms of irritation of the terminal nerves, acting either within or without the body. How these irritants act is a question not always easy to answer, but that the relation which they bear to the eruption is one of cause and effect is often evident to the most careless observer.

The external causes of the eruption (*U. ab irritamentis externis*) may be of a vegetable, animal, mechanical, or meteorological nature. The contact of the skin with certain species of *Urtica* or nettle (*U. urens* and *U. dioica*) is the most evident of all the external causes of urticaria or nettle-rash, and the one which has given to the disease both its scientific and its popular name. The stinging power which the nettle exerts is said to reside in minute tubular hairs or prickles which transmit a venomous fluid when pressed. Brendl found formic acid in the leaves of the urtica, and considers its elimination by the hairs to be the cause of the stinging. He agrees with Will that the acid exists in the hairs of the Bombyx processionea and in the stings of bees, wasps, and other insects. Buchner claims, on the contrary, that pure formic acid, when introduced by needles into the skin, does not produce wheals or tumors (*Schmidt's Jahrb.*, lxxviii., 279, 1850.) As far as I am aware, the healthy skin is never proof against the irritant action of the nettle, as is the case with other poisonous plants. In different individuals, however, a varying degree of effect results from its contact with the skin.

It is well known that the bites of mosquitos, bed-bugs, lice and fleas often evoke urticarial wheals, not only at the seat of attack but upon other portions of the body. In the case of the two latter pests, the exciting cause of the eruption is not infrequently overlooked. In this country we are fortunately not a prey to fleas, at least to anything like the extent which prevails in many portions of Europe, but urticaria from pediculi may occur not only in public but also in private practice, where the cause of the trouble is extremely apt to pass unsuspected. The disease is said to result also from contact with the slimy secretion of the jelly-fish and with certain caterpillars. Höfling (*Berl. klin. Woch.*, Dec. 2, 1872) states that urticaria met with upon the nape of the neck, in the spring, may be due to the contact of a hairy caterpillar of the genus Bombyx. He suffered personally from the eruption after sitting under a plum tree, and detected *in flagrante* what he considered to be its cause, viz., a caterpillar. In the same communication this writer cites another less credible cause of the disease. He claims to have observed urticaria around the anus, especially in the hot summer months, and attributes it to the irritant action of the fungus which clings to the seats of unclean privies.

That urticaria may result from mechanical causes, is clear to any one who will give his skin a sharp cut with a switch and observe the linear wheal or welt which quickly appears as a consequence (*U. factitia*). In some susceptible persons a somewhat similar lesion may be produced by the pressure or friction of wrinkled or constricting undergarments, especially those of some coarse fabric. Very many suffer from an irritable and pruritic state of the skin at the time of the autumnal change from light to heavy underwear, and a few have well-developed urticaria from this cause. Leopold reports a case of urticaria *febrilis* following the application of leeches to the sacrum, while Scanzoni (*Würzb. med. Zeitschr.*, I. 1., p. 92, 1860) and Schramm (*Berl. klin. Woch.*, Oct. 21, 1878) have observed the eruption appear immediately after leeches had been applied to the os uteri.

Weiss (*Berl. klin. Woch.*, July 25, 1881) has, in two cases, seen febrile urticaria follow the puncture of an echinococcus cyst. He attributes the eruption to absorption of some of the cystic contents, and not to the irritation of the skin by the puncture. Having never observed the eruption to follow the puncture of other cysts, he regards this as a pathognomonic sign of echinococcus. Finsen mentions the case of a boy of twelve who received a kick from a cow, which burst an echinococcus cyst, and produced immediately an urticaria.

That urticaria may result from the action of cold air upon the skin is evident from the following. Münchmeyer (*Berl. klin. Woch.*, May 17, 1875) relates the case of a soldier who suffered from urticaria upon every exposure to a cold wind. It usually appeared in the form of three large circular wheals upon the cheeks and chin. Ungar (*Berl. klin. Woch.*, Nov. 28, 1881) reports the case of a patient who, after a short stay in the open air, suffered from an extensive eruption of urticaria, followed in a few minutes by an attack of bronchial asthma. Upon return to a warm atmosphere the shortness of breath gradually subsided and the urticarial wheals vanished. Gull (*Guy's Hosp. Rep.*, vol. V., 1859) also mentions the coincidence of urticaria and asthma. This association of respiratory symptoms with urticaria is not uncommon, and would seem to indicate that the mucous membrane of the air passages suffers as well as the skin from urticarial attacks. A patient, recently under my care, stated that whenever he had a particularly severe attack it was preceded by hoarseness. The eruption and hoarseness were especially troublesome on getting out of bed in the morning, and both subsided in a few hours. He had suffered three years previously from a severe laryngitis which had left him in a very nervous and debilitated condition.

Sudden changes of temperature, such as are common in spring and fall, together with a certain electric tension of the atmosphere, have been.

cited as causes of urticaria, and Hebra states it is observed with special frequency whenever erysipelas prevails.

The internal causes of urticaria are more numerous than the external, and, for the most part, less susceptible of demonstration. They vary greatly in character, but are alike in so far as they produce their characteristic effect upon the skin, chiefly through the medium of reflex nervous irritation. They may be classified as dietary, medicinal, emotional, or morbid in character, and the resulting eruption must be regarded as a purely symptomatic one.

Urticaria from the use of certain articles of food (*U. ab ingestis*) usually appears in an acute form, with or without fever. In some instances the eruption appears with a marvellous suddenness, even before the offending substance has been fairly swallowed, and from this it would seem probable that the peculiar irritation of the nerves of taste is reflected immediately to the skin, and that the eruption is not due to the absorption of the substance and its circulation through the blood. The articles of food which have been observed to produce this singular effect upon the skin, in the case of certain individuals, are eaten by others with impunity. The list of such articles is an extensive one, and comprises fish, clams, oysters, lobsters, crabs, pork, eggs, honey, mushrooms, cucumbers, berries, fruit, etc., etc. In a given case it may be only a single article of food which will evoke the eruption, the others mentioned being entirely innocuous. And, curiously enough, this one article will almost invariably cause an eruption even when the person is unaware that it has been eaten.

Various medicaments are liable to produce urticaria in an acute form as an incidental effect of their action, and of late an unusual amount of attention has been paid to this subject. Many writers upon the action of drugs have carelessly spoken of the exanthem resulting in certain cases as "urticaria" or an "urticaria-like eruption." When a careful description of the cutaneous lesions has been given, it is often evident to one skilled in dermatological diagnosis that the eruption has not been a true urticaria, but either an erythema, a papular eruption tending to become pustular, or a dermatitis. At the same time, it cannot be denied that many of the medicinal rashes reported have been truly urticarial in character.

Quinine, valerian, copaiba, hyoscyamus, and chloral are the drugs which seem most likely to produce urticaria in ordinary practice. Morrow, in an interesting article on drug exanthemata (*N. Y. Med. Journ.*, March, 1880), states that the prevailing type of the quinine exanthem is erythematous; but in twelve out of sixty cases, the records of which he has collected, the eruption was described as "urticarial" with "puffiness of face," etc. He reports a case from his own practice of a gentleman who

suffered repeatedly from urticaria after taking a two, or even a one grain dose of quinine.

Slocum (*N. Y. Med. Record*, May 26, 1877) reported three cases of women who suffered from an urticarial eruption after taking quinine, and resolved never to take the drug again. Claiborne (*N. Y. Med. Record*, December 22, 1877) comments on these cases, claims that they are not uncommon, and states that after having for a long time attributed the urticaria of malarial districts to quinine, he finally concluded that the eruption was due to malaria, and that the drug should be the cure, and not the cause of the malady. He observed in his practice that this urticaria not only appeared always in malarial districts, but generally in old intermittent fever patients, that it observed a periodicity, and that it supplemented the paroxysm, recurring on the day and the hour when the patient ordinarily had his chill.

Kemper (*Cincin. Lancet and Clinic*, 1878, i., 285) observed the frequency with which urticaria attacked children who were taking sulphate of cinchonidia for malarial fever, and arrived at the conclusion that the drug was the cause of the eruption, and not the malaria, as he had previously imagined. Rankin (*Cincin. Lan. and Cli.*, 1878, i., 327) coincides in this conclusion respecting cinchonidia as a cause of urticaria. By disuse of the drug for a few days followed by its resumption, he observed the rash disappear and reappear in three cases. King (*Phil. Med. Times*, vol. ix., 1879, p. 251) reports the case of a lady who took five grains of sulphate of quinine in the morning on an empty stomach, a purgative having been given the preceding evening. In two hours, an urticarial eruption, with alarming general symptoms, ensued. The patient's sister and father had both been affected in a toxic manner by quinine. Ringer says that it is well known that quinine can produce urticaria, and according to Pflüger, the eruption will also follow the use of the decoction of cinchona.

That salicylic acid and its salts are often productive of urticaria is evident from cases narrated by Freudenberg (*Berl. Klin. Woch.*, Oct. 21, 1878). In these cases, the eruption was accompanied by albuminuria, both of which disappeared upon the withdrawal of the drug. Leube (*Berl. klin. Woch.*, June 24, 1878) reports the case of a rheumatic patient who had urticaria with albuminous urine after a four-gram (3 i.) dose of salicylate of sodium. A second dose produced the rash without the albumen. The writer speaks of another patient who had urticaria from no apparent cause, and whose urine was likewise found to be albuminous. In a case reported by Heinlein (*Randschau*, Bd. xix., 1878) salicylate of sodium was given for rheumatism in hourly doses of one-half gram (eight grains), which was increased to four grams (sixty grains). The first large dose was followed by redness and tingling of

the skin of face, chest, and legs, fever, and albuminous urine. Four days later, a similar dose evoked a marked eruption of urticaria.

Copaiba frequently produces an exanthem which is sometimes of an urticarial character. Neligan (*Diseases of the Skin*) mentions a case in which this drug was given to a woman suckling her infant, and urticaria appeared both on herself and on her child. Bartholow (*Mat. Med. and Ther.*, 1876) mentions this effect of copaiba, and remarks that it is not in consequence of a selective action on the skin, but merely the result of gastro-intestinal disturbance.

Chloral may likewise occasion urticaria. Chapman (*Lancet*, 1871) reports the case of a lady who took fifteen grains of chloral every night for two weeks. An erythematous eruption resulted, and disappeared with the discontinuance of the drug. Upon its administration two days later, wheals appeared suddenly over the whole body. Fisher (*Brit. Med. Jour.*, April 1, 1871) reports the case of a stout middle-aged woman to whom twenty-five grains of chloral were given at bed-time, and caused extensive urticaria. Four weeks later, a ten-grain dose produced the same effect.

In a case reported by Sieveking (*Brit. Med. Jour.*, Feb. 18, 1871) three grains of santonine given to a child of four was followed by vomiting, swelling of the face, and wheals upon the body. The soothing effect of a warm bath was followed in an hour's time by the disappearance of both the rash and the œdema. Russell (*Brit. Med. Jour.*, Dec. 9, 1871) cites a case in which a single enema of laudanum was followed by an outbreak of urticaria of alarming intensity. Kaufmann (*Berl. Klin. Woch.*, Feb. 21, 1881) reports a case of urticaria resulting from twenty-drop doses of tinct. pimpinellæ. A repetition of the drug evoked the eruption a second time. An eruption reported by Cabot (*Am. Jour. Med. Sci.*, Oct., 1851) as resulting from hyoseyamus, affected the face and body, the whole skin covering these parts being red, hard, and shining. The patient could hardly speak from stiffness of the tongue and lips. There were no typical wheals, and the eruption subsided soon after the third hourly dose was given.

Urticaria from a sudden emotion, such as anger, grief, or shame, is possible, and these causes have been noted. The only case resulting from such a cause which has come under my observation was that of a lady who was in the habit of appearing upon the stage. Under the excitement incident to her appearance before the footlights, an outbreak of red and tingling papules was very apt to occur suddenly, and to her intense annoyance, as may be imagined.

Disease or functional disturbance of internal organs constitutes a fruitful source of urticaria in its chronic form. The patient may believe himself or herself to be in perfect health, and it is only when the

annoying eruption leads the physician to make a careful investigation of the case that the departure from health is suspected. In derangement of the gastro intestinal canal will be found the cause of the eruption in a large proportion of cases. An altered condition of the mucous membrane may excite cutaneous disturbance by reflected nervous irritation. A chronic gastric catarrh, *e. g.*, although it may exist in hundreds of patients who never suffered from urticaria, is very liable to be associated with an irritable state of the skin, particularly of the face, and undoubtedly constitutes one of the several causes which usually act together in a given case to produce the eruption. The presence of worms in the intestinal canal has been alleged with great probability to constitute another important cause, but the most that can be said on this point is that the relation existing between urticaria and intestinal parasites offers a grand opportunity for clinical observation. I am not aware that the eruption has ever been attributed to the existence of *sarcina ventriculi*, but the rapid cure of certain obstinate cases by the administration of sulphurous acid might naturally suggest this origin.

It is not only by reflected nervous irritation that gastro-intestinal derangement evokes urticaria, but in a larger number of cases the imperfect digestion of the food undoubtedly induces a state of the blood which tends to excite irritation in the skin itself. We know that a certain systemic condition, not always easily demonstrated, is the very essence of gout and rheumatism. The same or a similar condition is regarded by most dermatologists as being at the root of eczema and psoriasis, and there is no less reason to assume that this is a potent factor in the etiology of urticaria. Certainly, the beneficial effect which so often results from a judicious stimulation of the liver and kidneys would seem to justify the assumption.

Uterine and menstrual derangements constitute a prolific source of certain phases of cutaneous disease, and to this source certain cases of urticaria may possibly be referred. The eruption has been known to occur in successive pregnancies, and its occurrence after the application of leeches to the os uteri has already been mentioned. The cases of urticaria tuberosa observed by Fouquet (*Berl. klin. Woch.*, Aug. 7, 1865) all occurred in women, and the eruption seemed dependent upon the state of the reproductive organs.

Many other pathological conditions might be cited as possible, if not probable, causes of urticaria. Still there would remain one important factor to consider, viz., idiosyncrasy. It is impossible to explain this "mystery of individuality." We can no more say why only one person in a thousand, or thereabouts, should suffer from urticaria after eating lobster than we can say why one among many should escape after thorough exposure to an infectious disease. Not one of the internal

causes of urticaria which have been mentioned will alone suffice to produce the eruption. There must be a certain sympathy existing between the skin and the internal organs, a peculiar temper of the nerves which is born with the individual, and which cannot be regarded as a pathological condition. In the production of urticaria, a most important part is played by the sympathetic, and particularly the vaso-motor nerves. The same remark, however, will apply with equal truth to many other affections of the skin, and there is no reason, therefore, for regarding urticaria as being in any special sense a neurotic disease.

Society Transactions.

NEW YORK DERMATOLOGICAL SOCIETY.

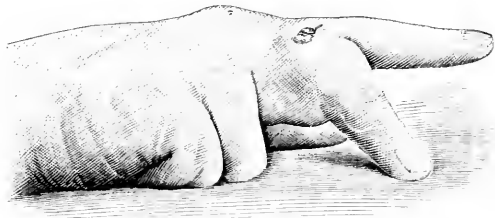
131ST REGULAR MEETING, NOV. 28, 1882.

DR. E. B. BRONSON, *President, in the chair.*

DR. R. W. TAYLOR read a paper on

DACTYLITIS SYPHILITICA.¹

After which Dr. G. H. FOX read the notes of a case of the same disease, and exhibited a photograph. The patient was a man of twenty-four, who had had syphilis for four years, and was of intemperate habits. About three and a half years after infection, his right middle finger began to swell, and has since gradually increased in size. Putting the hand in water and drinking liquor aggravates the pain of the affection. He has a gumma on the right forearm, two inches below elbow, and the affected finger is swollen, especially on its palmar aspect, and is of a dull-red color. It has never suppurated. There is tenderness over the



left tibia, and dark-brownish scars on both legs. The second joint of the finger appears unaffected, but the distal end of the metacarpal bone is enlarged. There is considerable lateral motion of the finger.

After about three weeks of mercurial treatment, the swelling of the finger was reduced slightly, and an ulcer had formed over it, with a yellowish base, formed by the swollen periosteum. Two weeks later, the finger had still

¹ To appear in the February number of this JOURNAL.

further decreased in size, the skin appearing too large for the enlarged bone, and separating from it so as to appear undermined when it was pinched up on either side of the ulcer.

After two weeks more, the finger had undergone still further diminution in size, and the ulcer had nearly healed. (He had been taking iodide of potassium for five weeks.)

DR. PIFFARD stated that he had met two or three cases of dactylitis syphilitica in private, and a few in public practice. He recollected one especially, some twelve years ago, in the person of a woman of middle age, in which he did not recognize the nature of the affection, and failed to cure the patient by appropriate treatment, Dr. Taylor not having at that time called attention to the disease. He believed that the name dactylitis syphilitica was still unfamiliar to the majority of physicians, although the disease is tolerably common.

DR. SHERWELL said that he had seen but one case of the affection, and that had yielded readily to treatment. He considered it a rare lesion.

DR. FOX said that the disease was rare enough to justify reports of cases. He thought it of great importance to be able to establish the diagnosis between the specific and the non-specific varieties of dactylitis, it seeming to him to be peculiar that the lesions might be identical in the two varieties, and yet the non-syphilitic forms prove very obstinate.

DR. STURGIS said that, in the cases which had come under his observation, the exacerbations at night were not marked. He thought that the absence of pain in the affection was peculiar. He was of the opinion that the co-existence of the rheumatic or gouty diathesis with syphilis increased the tendency to this affection, and that where these diatheses played a part, the joints were apt to be involved, in which event dry crepitation could be obtained. In dactylitis of purely syphilitic origin, the joints are not affected.

DR. BRONSON spoke of a case that he had seen in a child nine months old. No parental history could be obtained, but was told that one week after the child was vaccinated a swelling formed on the back of one hand. This had been incised. Later, swellings formed over the middle and ring fingers, the left big toe and left ankle. He could not obtain a frank history of syphilis in the child, except the statement that it had had "snuffles," and when he saw it, he discovered patches of thickened and exfoliated epithelium on the tongue, which he took to be remains of mucous patches. He also found what he regarded as vestiges of a gumma over one trochanter. He saw the case only once.

DR. ROBINSON remarked that he had seen several cases of non-syphilitic dactylitis, which did not present the symptom of pain on pressure, and which got well readily, without treatment. He regarded these cases as of non-specific origin, on account of the absence of any history of syphilis in the parents and of eruptions on the patients themselves.

DR. TAYLOR said that we are not justified in calling dactylitis either common or rare. When he wrote his monograph (in 1870), he had collected ten cases in all, to which he had added one of his own and one of Dr. Macready's. He had now seen eleven cases in all. He believes the disease to be rarer in acquired than in hereditary syphilis. As regards the differential diagnosis between the syphilitic and the non-syphilitic varieties, he thought that it could not be made in the absence of history of syphilis in the parents and of lesions in the children affected. However, if the lesion breaks down, its syphilitic origin is almost beyond doubt. As to treatment, he had found that the "mixed treatment" was better than the mercurial alone. With regard to the symptom of pain in the affection, he thought that the earlier in the course of syphilis the disease comes on, the worse it was. He said that there are two varieties of pain in the affection—one in the bones, and another due to simple distention of the skin by the swelling. In active cases of the disease, the pain is usually severe; in slow cases, slight. With regard to the relations between the rheumatic and gouty diatheses and syphilis, he alluded to a very courteous letter that he had received from Sir James Paget, concerning his paper on dactylitis, in which he (Paget) had spoken of one case of the disease in a gouty subject which he himself had observed, and asked whether these cases were not simply mixtures of gout, rheumatism, or scrofula with syphilis. He (Dr. Taylor) did not doubt that these diatheses might complicate syphilis, and greatly modify its course.

PRESENTATION OF CASES.

DR. FOX exhibited a

CASE FOR DIAGNOSIS.

The patient was fifty-two years old, a butcher by occupation, who had always enjoyed good health. He thinks he had acne when a boy. The present eruption began about nine years ago. It has not changed much since, and is usually a trifle worse in the fall and winter. It is situated upon the cheeks and scalp, especially along the upper line of the forehead. The lesions appear at the roots of the hair, and itch terribly, and are usually raw from scratching, and leave pits behind them. They mature in three or four days, disappearing in from seven to ten days later. New lesions come in crops every week or two, the patient never being free from them. The typical lesion of the disease is a papule, which softens, and a thick gluey substance exudes, which dries into a crust. When this is scratched off, a small circular punched-out ulcer is left, from the base of which one or two hairs spring. The growth of the hair has not been affected. The whole scalp is the seat of scattered lesions, but they are most numerous on the temples and along the frontal margin of the scalp, where there are abundant small, round white cicatrices, of varying depth, the skin presenting the appearance of having been pitted by variola. There are some pits on the cheeks, where the lesions have existed in the whiskers. Since the patient shaved, one month ago, no new papules have appeared on the cheeks. He has always shaved his chin, and the disease has never shown itself on this part. It is at present, and always has been, worse on the right side of the forehead. A few pits can be seen an inch or more from the border of the hair, and on the right side of the forehead there are four or five dull-red, flattened, slightly elevated patches, as large as a ten or twenty-five cent piece. These seem to have resulted from the coalescence of a number of papules. They came five days ago, and the patient says they will all be gone next week. There are one or two raw depressed points on their surfaces, and the patient says there was enough thick exudation upon them this morning to show on a handkerchief.

DR. ROBINSON said that he had never seen a case like this. He thought it an unusual form of acne, perhaps that variety to which Dr. Bulkley had applied the term "lupoid," which he considered unnecessary.

DR. MORROW had had two cases of this disease, one of which bore a striking resemblance to the present case, except that in his patient the disease did not extend so high up on the forehead, the pits being on a level with the ears. The papules in his cases had disappeared rapidly under the use of an ammoniated mercury ointment.

DR. FOX claimed that this was certainly a distinct affection of the skin. He had met with two other instances of the disease, one in an old gray-headed man with senile alopecia. The hairs were not affected in any of the cases. The characteristic features of the disease are the papules which exude, with or without being scratched, crust, and form pits. He thought that the sebaceous glands were primarily involved. The term "lupoid acne" did not seem an appropriate one to him. He could recall cases that he had called papular eczema of the scalp, but now thought might have been instances of the disease under consideration. He had found that an ointment of ammoniated mercury acted well in removing the papules, but that it did not prevent relapses.

DR. TAYLOR suggested that the disease might be the "dermatitis papillaris capillitii" which had been so well described by Dr. Hyde in the last two numbers of the JOURNAL OF CUTANEOUS AND VENEREAL DISEASES. That disease is a perifolliculitis, with infiltration of the tissues around the follicles, and subsequent absorption of the inflammatory material. He had never heard of this disease

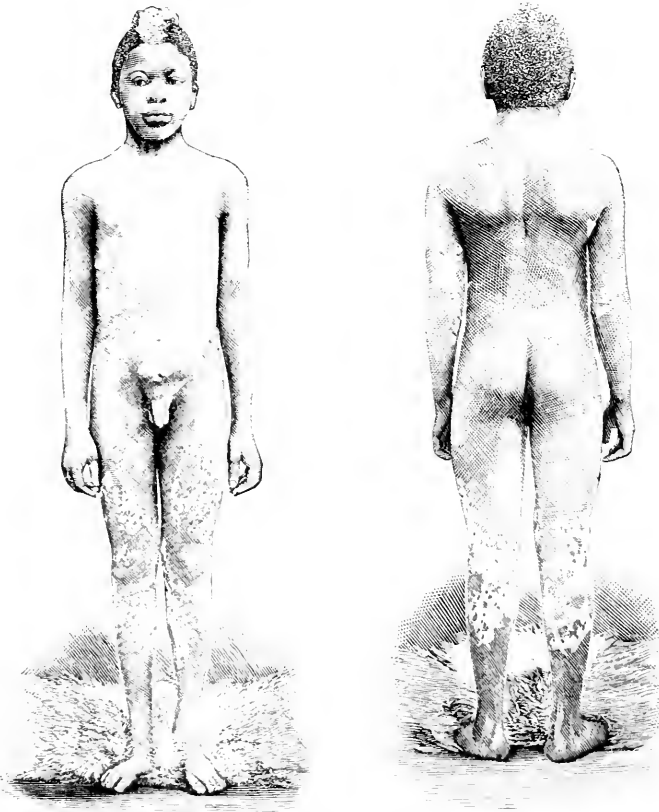
occurring on the face, it being usually confined to the back of the neck, but he could think of no reason why it should not also occur on other parts.

DR. WEISSE said that he had met similar cases, in which, he thought, the disease began around the sebaceous follicles, and ran the same course as in the case of Dr. Fox, appearing on the brow, nose and cheeks, progressing slowly and leaving pits. In his cases the disease differed from acne atrophica in that it began in the form of papules, scabs, and finally cicatrices being developed without rupture of the papules. In all of his cases the patients were men in middle life, the lesions usually running along the eyebrows and the edges of the beard and moustache, leaving lines of pits.

DR. PIFFARD exhibited a case of

LEUCODERMA IN A NEGRO BOY.

Ashberry Benjamin, twelve years of age, was born in Mississippi. His parents are full-blooded negroes, and are still living in that State. They were formerly slaves. Seven or eight years ago a white spot appeared on the abdomen, followed



by similar spots on the legs; later additional white patches appeared, the process being a gradual one, until we find him in the condition now presented. The boy is well developed, well nourished, and of average size. There appear to be no anomalies of skin secretion or function.

DR. PIFFARD exhibited the photograph of a case of

PSORIASIS AFTER VACCINATION.

M. H., female, aged nineteen, applied for advice November 16, 1882. She stated that in December, 1881, she was vaccinated with bovine virus. As there was no result at the end of a week, she was revaccinated with bovine virus. This time there was no vesicle, but instead a red raised patch, similar, she said, to the patches that subsequently appeared on the body. A few weeks later, small points of eruption appeared on various parts of the body, coming first on the backs of the hands, and subsequently elsewhere. None of them were larger than a ten-cent piece. The eruption lasted all winter, but lessened during the summer. It has now returned more freely.

On examination there were found isolated patches of typical psoriasis on the arms, legs and hips, most of them from a quarter to three quarters of an inch in diameter.

The patient had been vaccinated in infancy and since without mishap. She had suffered from chorea in childhood. Her general health is at present pretty fair, except that she menstruates every three weeks, and with great pain, the flow usually lasting five or six days. She is a small eater, but lives chiefly on meat. She is remarkably hirsute on the body, arms, and lower limbs, but not on the face. The treatment ordered was vegetable diet, arsenic internally, and chrysarobin-collodion externally.

DR. ROBINSON said that at the recent meeting of the American Dermatological Association, he had reported a similar case.

Selections.

SYPHILIS AND MARRIAGE.

FRED. W. LOWNDES, F.R.C.S., writes on this subject in the *Lancet* of July 8, 1882, as follows:

. . . Now, it is no less remarkable than true that those men who may with perfect safety marry, never having had syphilis at all except in their own imaginations, are those who are the most anxious and dubious about doing so, consulting their own and other medical advisers, and being with great difficulty persuaded that there is no danger in their marrying. On the other hand, those who take no medical advice on the subject are too often the very ones who ought to do so, taking the irrevocable step of marrying within a recklessly short period of having suffered from syphilis, or even before its primary manifestation has quite disappeared. Hence, it follows, naturally, that many married women suffer from syphilis, and suffer very severely, the approach of the disease being to them insidious and mysterious, occasioning great reluctance to seek medical advice until much valuable time has been lost.

A man comes to consult us. He says he is going to be married in a few days, that he has had impure connection very recently, and he wishes to have some prophylactic against any disease he may have contracted. On examining him, we find no disease whatever. But we all know that the period of syphilitic incu-

bation is one of weeks rather than days, and instances of seven, and even of eight, weeks have been proved beyond doubt. This is not a mere point of theoretical interest, but one of great practical importance. Although our patient may be perfectly healthy apparently, he may, nevertheless, have syphilis incubating in him, and a few weeks will suffice to remove all uncertainties. Hence, it is manifest that the only prophylactic we can safely prescribe is a postponement of the marriage for at least three months from the date of impure intercourse. I am unable to give any case in my own practice showing the disastrous results of this recklessness, which is much too common: but a very good illustration is given in Fournier's work, under the note "Syphilis contracted before marriage, and developing itself afterwards." The result of the case is thus summed up:

1. Coitus a fortnight before marriage with a woman afflicted with vulvar syphilides.

2. Marriage in full state of health.

3. A fortnight after marriage the appearance of a syphilitic chancre, followed at the usual time by general symptoms.

4. Infection of the young wife by the husband's chancre, the nature of which was misunderstood when it appeared.

Sometimes we are consulted by men with sores on the penis who are about to be married in a few days. Obviously, marriage is out of the question, and must be adjourned *sine die*. I should not think it necessary to say this if I had not seen such cases, and found it very difficult to dissuade at least some men from marrying in such a condition.

But the most frequent and far the most anxious cases are those of men who have undoubtedly suffered from syphilis more or less recently, sometimes being under our own treatment, and who wish to know whether they can safely marry. These cases present grave difficulties, and involve us in very serious responsibilities. We are between two fires. On the one hand, nothing could be so terrible as to incur the responsibility of sanctioning any marriage which might result in the syphilitic infection of the wife, in however mild a form. On the other hand, to forbid marriage upon what may afterwards turn out to have been insufficient grounds would be to incur a responsibility only secondary to this. It is generally admitted that no disease is so amenable to treatment as syphilis, and, therefore, the fact of a man having had syphilis does not of itself constitute a bar to marriage. Fournier gives the following as the conditions under which a man who has had syphilis may marry:

1. Absence of actual specific symptoms.

2. Advanced age of the diathesis.

3. A certain period of absolute immunity since the last specific manifestation.

4. The non-menacing character of the disease.

5. A sufficient specific treatment.

He also gives notes of eighty-seven cases of men who, having suffered from syphilis, married, and subsequently became fathers between them of a total of one hundred and fifty-six children absolutely untouched by the disease, and in thirty-five of these cases, various symptoms of an unquestionably specific character developed themselves after marriage, without the wives or children of these patients in any way being affected by the disease. While admitting the reassuring aspect of this latter fact, he very properly warns us not to exaggerate its bearing nor to strain it to mean more than it really does.

By the term sufficient specific treatment, he explains his meaning to be that mercury and iodide of potassium are to be administered in really active and cura-

tive doses, intermittingly for at least three or four years. Even then he advises delay before marrying, but gives his consent if the patient has gone on for eighteen months or two years without symptoms, and if he be otherwise in good condition. Mr. Jonathan Hutchinson, who writes the preface to the English translation, says: "I feel scarcely prepared to go the full length which M. Fournier suggested in the direction of caution and prohibition. . . . Respecting a malady so common as syphilis, whilst it is often our duty to warn, it is also not unfrequently equally our duty to encourage." With this most of us will agree, but I must express my regret at the following sentence of Mr. Hutchinson's: "The surgeon who, on account of past syphilis, forbids marriage to an otherwise eligible man, must remember that he forbids it at the same time to some woman who possibly, if well informed as to her risks, would willingly encounter them." Now, I maintain that no woman should be permitted to encounter such risk, and neither man nor woman is justified in exposing to this risk an unborn child. It seems to me that each case must be judged on its own merits. When the constitution is good, and there has been sufficient specific treatment, marriage may be permitted within a much shorter period than M. Fournier suggests, and with safety. Syphilis alone, and syphilis combined with scrofula, are two very different foes to contend with; and if our patient be of a scrofulous temperament, a delay even longer than M. Fournier's may be desirable. In all doubtful cases, we shall do well to seek consultation with one another, specialists consulting freely with all-round physicians and surgeons, and with obstetricians. This should be done to avoid specialism becoming narrow and routine, especially when we remember how that syphilitic diseases penetrate through every nook and cranny of medical, surgical, and obstetrical practice. I have been frequently urged to try non-mercurial treatment, but have always been deterred from doing so by the words of the late Dr. Thomas Edward Beatty, a pupil, be it remembered, of Richard Carmichael, in his address at the annual meeting of the British Medical Association, at Leeds, in 1869: "Mercury given to the man when first diseased would, I firmly believe, have prevented this terrible calamity, *i. e.*, the syphilitic infection of the wife; and I would now humbly suggest to all who undertake the treatment of venereal disease, that if they have a certainty that their patients will remain celibate all their lives, they may heal up their sores and dispel their eruptions and sore throats in any manner they like; but that they have no right to expose the pure, innocent, high-minded females of society to contamination by marrying men treated without mercury."

SOME CASES OF NOMA PUDENDI.

The term of noma occurs at an early date in medical writings, even so early as the time of Hippocrates, who applies it to putrid and eroding ulcers. Subsequent writers have unfortunately used the word with a latitude of application, which, however convenient as a *refugium ignorantie*, is scarcely consistent with precision and accuracy of description. Vogel, in the sixteenth century, applies it to that form of gangrene of the cheek which is much more generally known as cancrum oris, and in an excellent modern treatise, that by Dr. J. Lewis Smith, a similar application is made of it; on the other hand, in several of our standard works on children's diseases, the term is not to be found at all. Under the name of noma pudendi, I propose to give a short account of some cases illustrating an affection of the external genitals in female children, which has been fitly called noma pudendi, also cancer aquaticus, and by Velpeau

gangrenous inflammation of the vulva: though in these islands, at least, gangrene is but an exceptional sequel or concomitant of it. The only writer, so far as I can ascertain, who describes this formidable malady is Mr. Kinder Wood, who forcibly depicts its course and symptoms, and lays down excellent suggestions for its treatment. His language is so perspicuous and concise that I shall make no apology for quoting largely from his monograph. It commonly happens that the diseased condition is already fully developed before medical aid is sought, but in a few recorded cases these symptoms preceded by about thirty days the affection of the pudendum—chilliness, succeeded by heat, slight headache, loss of appetite, thirst, torpor of the bowels, and general languor. Pain in micturition commonly first directs attention to the genitals, which will be found enlarged, inflamed, and of a livid color. Generally within twenty-four hours from the inception of the inflammation, the inner and outer surface of the labia are covered by a crop of vesicles, which quickly burst, and leave as many superficial ulcers, from which flows a dark offensive ichor, so acrid and irritating that all the adjacent parts, as far back as the anus, as well as the inner and anterior surfaces of the thighs, become excoriated, and, in severe cases, ulcerated. After the inflammation begins, the pulse is quick and weak, and as the ulceration extends, the face becomes of a peculiar pallid hue, which is very pathognomonic of this affection. At this stage, too, retention of urine becomes in some cases a very prominent and troublesome symptom. When early treatment has been neglected, or the attack is of a severe type, the deep foul ulceration invades successively the parts contiguous to the original seat of the disease, and a fatal termination, preceded and hastened by intractable diarrhoea, takes place, commonly within ten or fourteen days. When, on the other hand, early and judicious treatment has been adopted, the ulceration may be arrested, and even partly healed within a similar period, though for several weeks after the peculiar pallor of the face, general debility, and a copious unhealthy vaginal discharge testify to the trying nature of the primary attack. Mr. Wood concludes, and I think justly, that the affection, of which these are the salient features, should be regarded as a disease of a distinct and specific nature. From erysipelas infantilis it is easily distinguished, as this occurs shortly after birth, attacks male and female children alike, is followed by early and copious suppuration, not infrequently by mortification, and often death, the abdominal viscera have been found glued together by inflammatory exudation, whereas in the body of a child who had died of the disease under consideration the abdominal and thoracic viscera were found free from disease. In mild cases, it has been mistaken for purulent vulvitis, which is a comparatively common affection, unattended with any constitutional disturbance, and sometimes lasting for several weeks without any apparent injury to the child's health. It deserves to be remembered, however, that both these diseases have from time to time been made a ground for preferring charges of the vilest immorality against unoffending persons: of this fact Mr. Wood gives a very striking illustration. A child, aged four years, who had slept in a bed with a lad aged fourteen, was admitted into Manchester Infirmary with an inflamed and swollen condition of the external genitals, and notwithstanding treatment, died in a few days. An inquest was held, at which Mr. Wood expressed his opinion that death was the result of violence, and a verdict of murder was returned against the boy with whom she had slept. Fortunately for him, several similar cases, affording no ground for such suspicion, occurred shortly afterwards, and Mr. Wood, seeing his mistake of diagnosis, informed the authorities of his altered opinion, and procured the boy's release. In connection with the differential diagnosis, another disease calls for

passing notice. I mean that form of pemphigus to which Dr. Stokes, in an essay published many years ago, applied the term gangraenous, its popular name being "burnt holes." This affection attacks young and ill-fed children, and is marked by the formation of vesicles, ending in destructive ulceration, and not infrequently gangrene. I cannot, however, conclude, as Dr. Mansell and Evanson did, that the disease so graphically described by Dr. Stokes is identical with noma pudendi, though they have many characteristics in common, and call for somewhat similar treatment.

I have seen in all five cases of noma; all of them occurring in children under three years, except one, which had reached the age of eleven. The first, and only fatal case amongst these, was a wretched infant not quite a year old, whose mother had left it to the tender mercies of an old woman residing in a village not far from Dublin. The disease was already well developed when I saw it first, and my efforts only availed to prolong its life for a few days. The four remaining cases recovered, though satisfactory convalescence was but tardily established. In the early stage I found that warm bread poultices gave relief and allayed the inflammation, and when that end was attained, the continued application of some mild antiseptic dressing, such as carbolic oil in the proportion of 1 in 40, materially expedited the healing of the ulcers; the arrest of the acrid discharge will be much hastened by frequent syringing with warm water and Condyl's fluid. At the same time, a liberal supply of nourishment and wine, in suitable quantities, were allowed, and quinine with muriatic acid was advantageously exhibited.—R. D. PUREFOY, M.B., *Dublin Journ. Med. Sci.*, June, 1882.

[An interesting case of *noma pudendi* is reported by Dr. Anna Luken, in the *New York Medical Journal* for Oct., 1882.—Eds.]

PELLAGRA.

Pellagra is a constitutional affection characterized by symptoms pertaining respectively to the skin, the digestive apparatus, and the nervous system. It results in a state of general cachexia, and usually terminates fatally. It is endemic in certain countries, although it may occur sporadically anywhere. It was first observed in Spain so recently as 1730; about fifty years later it appeared in the northern portion of Lombardy. In 1794, it was described by Strangliosi in terms exactly suited to the disease as it now appears. Since then, much has been published concerning it, and the disputed points involved in its etiology have received particular attention. Casali, who recorded the earliest known cases of pellagra, attributed its origin to the use of maize or Indian-corn as an article of food. Balardini regarded it as due to a disease of the same grain corresponding to the ergot in rye. Others, however, have pointed out that the malady is confined to no particular districts, but is met with in subjects who have never made use of maize, and never visited either Italy or Spain. Similar cases to these last have come under our observation every year in the *Hôpital St. Louis*. The question we see is still *sub judice*. But while the disease prevails among the peasants of Lombardy to a lamentable extent, the inhabitants of Southern Italy, though large consumers of maize, are entirely exempt from its ravages; and the results of recent investigations ordered by the Government of the Kingdom would seem to prove that extreme poverty and unfavorable hygienic surroundings have much to do with its production. In short, it is safe to conclude that the principal causes of pellagra are destitution, alcoholic excess, and the exclusive use of maize, assisted by the enervating effects of a hot climate.

However this may be, the diagnostic features of the affection are unmistakable. It begins with a precursory stage, consisting of spasmodic symptoms, heaviness of the head, dulness of intellect, pains in the spinal region, and melancholy, together with a sensation of heat in the stomach, like heartburn, loss of appetite, and difficult digestion. These are succeeded, after an interval of a few weeks or months, by the peculiar cutaneous symptoms, which are manifested on the back of the hand, and sometimes in other situations. These begin with an exanthematous redness, of a brownish or bluish shade, which spreads uniformly over a smooth surface, and disappears momentarily under pressure. This redness continues for days or weeks until the period of desquamation, then the skin peels off in thin whitish layers, like the coats of an onion, which are constantly renewed, and finally become of a brown color. In some cases there is an eruption of vesicles, or even of bulke, resembling pemphigus. The complaint may now disappear entirely, but, as a rule, the patient is subject to relapses. The above-described symptoms may return year after year with warm weather, receding at the approach of winter, until, in the course of time, the affected hand becomes permanently dry, wasted, and fissured, presenting a very characteristic aspect. The face is sometimes similarly affected, or the complexion may become bronzed, as in Addison's disease, to which the phenomenon was for some time erroneously attributed. The cutaneous discoloration seems to be due, in part at least, to the chemical action of the solar rays on the tissues of debilitated subjects.

The gastro-intestinal disorders attendant on pellagra—dyspepsia, pyrosis, and especially an uncontrollable diarrhoea, sometimes of a dysenteric character—have been found to be unconnected with any serious pathological lesions.

When the complaint is fully developed, the lips are cracked, the tongue is rough, deeply furrowed longitudinally, and red, as if burnt, with prominent papillae, as in scarlatina. The buccal mucous membrane is also inflamed and ulcerated, the gums are spongy, soft, and swollen, and sometimes the teeth become loose.

As the disease advances, the nervous system is more and more involved; the mind is enfeebled, the memory impaired, and the sadness deepens into melancholy, which often impels the victim to suicide. To these are added a general paralysis, and in particular a weakness of the lower extremities, which, together with vertigo, is a cause of frequent falls when walking.

The progress of the malady is slow, and it usually continues for a series of years, with annual intermissions, unless cut short by some subsequent affection. Recoveries are of rare occurrence.

Treatment consists in a thorough change of hygienic surroundings, improved nourishment, and the prohibition of overwork, together with tonic remedies and sulphur-baths.—HARDY, *Gaz. des Hôp.*, Aug. 31, 1882.

ON THE INTERNAL ADMINISTRATION OF IODOFORM IN CONSTITUTIONAL SYPHILIS.

MRACEK gives the results observed, some three years ago, in a large number of hospital cases, from the internal use of iodoform under the direction of Prof. v. Sigmund; the object being to ascertain, first, *the effect of the medicine, when thus administered, upon the progress of syphilis*, and secondly, *its proper dose in such cases*.

Freshly-prepared pills were made use of, each containing 0.1 of iodoform.

In the eruptive stage of the complaint, it was employed chiefly against the insomnia, and the pains in the head, limbs, and respiratory muscles. The favorable

effect of *iodine* on these symptoms being borne in mind, much was naturally expected from the iodoform containing 95.8 per cent of that element. The action of iodoform in small doses (0.5) was found, however, to be far from prompt in any case, and it sometimes failed to exert any sedative influence whatever. On the other hand, larger doses (1.0 and 1.5) while operating with more certainty as narcotics, sometimes gave rise to very disagreeable affections of the head.

The secondary manifestations of syphilis, as maculo-papular eruptions, papular syphilides on the genitals and anus, papule in the mouth, pustules on the hairy scalp, iritis, palmar and plantar psoriasis, etc., proved still more refractory under this mode of treatment. In most of these cases it was necessary to fall back upon mercurial inunctions, either to shorten the course of the original disease or to combat the effects of the iodoform. Even when the latter was tolerated, so that its administration could be continued to a cure, the patient's general condition was less satisfactory than when mercury was relied on.

The course of the disease in the gummatous stage was more favorably influenced; but unfortunately, owing to increased debility, the remedy was less easily borne than at an earlier period, and often produced such troublesome symptoms as to compel its speedy discontinuance.

Gastric disturbances were the most frequent results from the administration of iodoform. A daily dose of one gramme almost uniformly gave rise to loss of appetite, nausea and vomiting, and sometimes to diarrhoea. Less frequent but equally characteristic effects were, a persistent drowsiness; vertigo and feelings of intoxication; hebetude and pressure in the head; general excitement, occasionally with accelerated action of the heart; acne (after ten, eleven, thirteen, thirty-four days' treatment); scraping in the throat, cough, acute catarrh of the fauces, as also of the conjunctiva; more rarely, bronchitis. Lastly, when these conditions did not obtain, after taking the iodoform for seventeen to thirty-five days, a feeling of debility and faintness was sometimes experienced, and the patient became pale and lost flesh.

The author decides that the internal administration of iodoform is inadvisable in the treatment of syphilis, both on account of its uncertainty as a curative agent, and the disagreeable symptoms so frequently attendant on its use. On comparing the preparation of iodine hitherto most frequently employed—viz., iodide of potassium, containing seventy-six per cent of iodine, with iodoform containing ninety to ninety-five per cent, he arrives at the following conclusions:

Both operate by virtue of their iodine. The iodoform, however, is seldom tolerated, for many days together, in doses as large as 1.0 *pro die*. This is scarcely ever the case with iodide of potassium. The iodide, therefore, as not affecting the appetite, and less frequently giving rise to gastric disturbances in general, is far preferable to iodoform in the treatment of syphilis. If reduced doses (0.5) of iodoform are resorted to, a much smaller quantity of iodine is supplied to the organism than when iodide of potassium, in the easily-borne dose of 1.0, is administered. The author would hardly venture upon the 3.0 doses of iodoform employed by Nunn. The most frequent secondary effects from iodide of potassium, viz., acne and catarrh, are, it is true, more rarely caused by iodoform, but are sometimes observed even after the exhibition of the latter.—*Monatsh. f. prak. Derm.*, May, 1882.

THE BACTERIA OF PEMPHIGUS.

M. PAUL GIBIER has published, in *Ann. de Dermatol. et de Syphilis*, for February, the results of his investigations into the etiology of acute febrile pemphi-

gus. After showing that the real nature of this affection, although hinted at by a few preceding authorities, had never been decidedly affirmed, he formulates as follows the general conclusions to which he has arrived.

The microbe of acute pemphigus is a bacterium, composed, when full-grown of a series of joints arranged in chaplets, and measuring in breadth $\frac{1}{1500}$, and in length from $\frac{1}{1000}$ to $\frac{1}{100}$ of a millimetre. Each chaplet consists of from two to twenty of these joints, which merge into one another where they come in contact. This bacterium is quite lively in its movements for so minute an organism.

At an earlier stage of development, it consists of rounded granulations similar to those of which "rods" are composed, but occurring singly or in groups, sometimes without order, sometimes as zooglææ.

These bacteria are found in the liquid from recently formed bullæ.

The urine, in cases of the disease, contains large quantities of them.

They can be reproduced by the culture-process, from either of the above-mentioned fluids.

Subcutaneous injection of the liquid from the bullæ has hitherto produced no effect upon the lower animals.

The symptoms of acute pemphigus are those of an infectious fever. Its termination is often fatal.

Its anatomical lesions correspond to those from blood-poisoning.

The disease is of comparatively rare occurrence, and until recently was believed not to occur in the adult.

Although M. Gibier has so far failed to detect the bacteria of pemphigus in the blood, he is inclined to the opinion that it may nevertheless exist there, since it is found both in the urine and in the liquid of the bullæ, which latter is merely transuded blood-serum. Nor is this the only example of a disease in which similar organisms have been undiscoverable in the blood, while abundantly present in the other fluids.

A fatal case of acute pemphigus, treated by M. Vidal, in the Hôpital St. Louis, is adduced in detail, as confirmatory of the author's views. He claims that, in this instance, the infectious nature of the disease was clearly established, both by clinical and microscopic observations.

The fact that experiment has failed to demonstrate the inoculability of pemphigus is not regarded by M. Gibier as negating his conclusions, since it is known that the lower animals are not liable to all the diseases of humanity, and, moreover, it is possible that this affection is only contracted by exposure for a lengthened period to the influences which produce it.

As the liquid from the bullæ has often before been subjected to analysis, it may be asked why the true character of the malady was not discovered long ago. M. Gibier thinks it was because these examinations were almost wholly confined to cases of *chronic* pemphigus, in which only a few indolent bacteria are to be found on careful search, and sometimes the urine does not contain them at all. Yet the fact that they undoubtedly exist, as genuine pathological products, in this form of the disease, would seem to show that the theory which ascribes the origin of the latter to a nervous lesion, can no longer be regarded as correct.

The author points to the striking similarity which is traceable between the symptoms of acute pemphigus and those of yellow fever, cholera, diphtheria, puerperal fever, etc., and affirms that this evidence is fortified by the results of post-mortem examinations.

Finally, he maintains that, since acute pemphigus is now known to be caused

by an organic ferment, it should be combated by suitable antizymotic agents; and that hypodermic injections of phenic acid, antiseptic enemata, and the methodical exhibition of the salicylates and of permanganate of potash may be relied on, even in the worst cases, with the fairest prospect of success.

PRURITUS ANI.

DR. N. L. FOLSOM has found the essence of peppermint, repeated as frequently as necessary, extremely valuable as a direct application in pruritus ani. In addition, with a view to relieve the condition of which the itching is a symptom, he advises an ointment of alum and bathing the parts with cold water on retiring for the night.—*Mich. Med. News*, October 25, 1882.

Correspondence.

MALARIA IN SKIN DISEASES—A CORRECTION.

To the Editors of the Journal of Cutaneous and Venereal Diseases:

GENTLEMEN:—Some time since the following paragraph appeared in the *Michigan Medical News*, and has been widely copied in the medical journals of the country:

A century ago John Hunter divided all skin diseases into three classes, one of which is cured by mercury and the iodides, a second by sulphur, and a third class which the devil himself can't cure. Dr. L. P. Yandell, who quotes Hunter as above, is given credit for a much less complex classification than even this. He attributes all skin eruptions to malaria. Quinine is a specific for malaria; ergo, quinine is the remedy for all skin eruptions. Q. E. D.

I trust that my confrères of the press will do me the kindness and the justice to publish the correction now given, as the matter is not only one of personal interest to the writer, but is of scientific interest to the profession. The subjoined extracts are from a supplement to a report read to the American Dermatological Association, September, 1877. A copy of this report will be gladly sent to any one desiring it:

"From the criticisms which have been made on my views, I find that I have not succeeded in making myself perfectly understood. What I have contended for, and what I have reiterated is simply this: Malaria is *the chief source of acute skin disease*. Scrofula is *the chief source of chronic skin disease*. The more inveterate cases of skin disease are often due to the co-existence of these two things. The specific exanthems, of course, are not included here, but I contend that their progress and termination are often largely influenced by the presence of malaria or struma. *I do not claim* that malaria and struma are the *sole* causes of the dermatoses. Indeed, *many* of the dermatoses may exist *independently of malaria or struma*, and most frequently some exciting cause is necessary to develop the cutaneous eruption. Among the exciting causes are irritants, injuries, insufficient or improper ingesta, vicissitudes of temperature, alcohol, dentition, menstruation, parturition, lactation, etc. The proofs of the truth of

my views are, in the first place, that the diseases of the skin are cured more certainly and more quickly by the antimalarial remedies, on the one hand, and by the antistrumous on the other, than can be done by any other line of therapeutics; and, in the second place, that careful and painstaking investigation will, in the majority of dermatoses, make apparent the existence of the malaria or the struma, as the case may be.

"In conclusion, I desire to impress upon the reader that my views *are not confined to the skin diseases*. What produces disease here will produce it in all other organs of the body. What is true of dermatology is equally true of gynecology and ophthalmology and otology, and it is just as true of the diseases of all the other regions of the body."

Subsequent observation has confirmed my belief in the correctness of these views.

LUNSFORD P. YANDELL.

LOUISVILLE, KY.

Received.

The Laws of Life and their Relation to Diseases of the Skin. By J. L. MILTON. London, 1882: Chatto & Windus.

Lehrbuch der Hautkrankheiten von Dr. GUSTAV BEHREND. 2te Aufl. Berlin, 1883: Hirschwald.

Items.

ANNALS OF ANATOMY AND SURGERY.—This publication begins the new year as an independent journal, freed from the trammels of a local society. It is, we believe, the only journal specially devoted to these subjects in the English language, and gentlemen interested in them would do well to consider its merits and claims when making up their journal-list for the year.

ARCHIVES OF DERMATOLOGY.—The following appears on the editorial page of the October number of the *Archives of Dermatology*: "With this issue and the completion of volume viii., the *Archives of Dermatology* will cease its existence. For several years the pressure of other work has rendered it very difficult for the editor to devote sufficient time and energy to its publication, and the recent appearance of a monthly journal of cutaneous and venereal diseases has seemed to offer a fit occasion for its discontinuance. The interests of dermatology will be well served by the new monthly, while the *index medicus* furnishes references to dermatological literature, which occupied much space in the pages of the *Archives*."

PLICA POLONICA.—DR. LESSING reports a case of this rare disease that he met with in a young Polish woman in Minnesota. He does not agree with the view of Hebra, that the affection is simply the result of eczema and filth.—*Phil. Med. Times*, November 4, 1882.

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ECZEMA: ITS PATHOLOGY AND PRINCIPLES OF TREATMENT.¹

BY

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MOST descriptions of the pathological anatomy of eczema are chiefly occupied with the changes that take place in the cutis, more especially in its papillary layer. The alterations to which the epidermis is subjected appear generally to have been regarded as of subordinate or secondary importance. It is true that some of the most striking, as well as earliest manifestations of the disease, such as the heat, redness, swelling, papulation, clearly point to vascular disorder in the true skin; while the thickening that characterizes the later stages is almost wholly due to pathological products accumulated in the tissues underneath the epidermis. Yet it may be shown that the latter structure with its complex layers, constituting the superficies of the skin, upon which the peculiar characters of the integument principally depend and out of which its chief appendages are evolved, plays a part in the pathology of eczema no less essential than that of the vascular stratum beneath. Indeed, there are reasons for believing that the epidermic lesions of the disease possess a primary, an initiative character that tends to mark the epidermis as the focal point of the eczematous process.

Vesiculation, as explained by many authorities, so far as the epidermic cells are concerned, is merely a passive process. The serum escaping from the blood-vessels of the papillæ forces its way into the mucous layer,

¹ Read before the New York Academy of Medicine, Jan. 18, 1883.

crowding the cells asunder, and in the intercellular lacunæ, formed chiefly by elongated spindle-cells that have wandered into the epidermis from the vessels of the corium, the accumulating fluid becomes a vesicle. But the researches of Vulpian and others have shown that the cells of the rete participate more actively in this process. Certain of them undergo a sort of dropsical degeneration, especially those in the inter-papillary spaces. Their nuclei disappear, and their protoplasm becomes transformed into a fluid substance, which gradually increases by imbibition of serum supplied from vessels below. At length, several such "dropsical" cells, contiguous to one another, coalesce through rupture of their cell-walls, and the collection of fluid thus formed constitutes the vesicle. According to Gaucher,¹ a reticular mesh-work remains where the vesicle has formed, consisting of the remnants of the walls of the obliterated cells. This explanation of how vesiculation and exudation are produced serves to account for the peculiar properties of the fluid exuded from an eczematous surface, differing as they do so materially from those of ordinary serum.

Meanwhile, according to Suchard,² as the vesicle gradually approaches the surface, a marked alteration takes place in the stratum granulosum. Ranvier had already shown that there is always a definite relation between this layer and the stratum corneum. In the normal condition, a fluid substance (*écléidine*) is formed in the stratum granulosum and diffused through the stratum lucidum. This substance, it is claimed, plays an important part in the process of cornification. It is always abundant where the cuticle is thick, as upon the palms and soles, while in situations where it is thin, the stratum granulosum is much reduced in thickness and no fluid is diffused through the stratum lucidum. In situations where the corneous layer is undeveloped, as upon the lips, the stratum granulosum and stratum lucidum disappear entirely, and the cells of the superficial layer retain their nuclei. Similarly, in certain pathological conditions, Suchard found that impairment of the granular layer was accompanied with failure of cornification. In scaly diseases, like psoriasis or the squamous form of eczema, the granular layer was absent, and the superficial cells of the epidermis retained their nuclei and failed to become corneous. The granular layer disappeared in the same way over the eczematous vesicle.

Doubtless all the metamorphic changes that the epidermis undergoes in eczema have not yet been described. Further investigation, it may reasonably be supposed, will add materially to their complexity and importance. Enough have been shown to indicate an independent action on the part of the epidermic cells in the inflammatory process of eczema.

¹ Ann. de Derm. et Syph., 1881, 2 S., II., 263-7.

² Arch. de Phys. Norm. et Path., 1882, 2 S., X., 205-212.

"The doctrine of emigration" fails to account for the vesicular process that takes place in the rete, as it does for the endogenous formations that mark the inflammation of other non-vascular structures, such as the cornea, cartilage tissue, or the epiploa. The formative changes that take place in these structures when inflamed originate in the normal, indigenous cells of the part, and not in cells that have wandered from the blood-vessels. But though the pathological process is initiated in the cells of these structures, the adjacent vascular tissue soon sympathizes. And so in the skin. The papillary vessels respond to an irritation in the epidermis as do the subconjunctival vessels in irritation of the cornea.

But, before proceeding further, let us consider what are the qualifications of the epidermis for initiating an irritative process in the skin. First, in this connection, a word with regard to the subject of the cutaneous nerves. It was long supposed that the nerves of the skin did not extend beyond the papillary layer. The corpuscles of Meissner and Krause, which occupy a portion of the papillæ, are yet commonly regarded as the special organs of the sense of touch. But the fact that they are not everywhere present shows that they are not absolutely essential. It is now well known that the nerves do not all stop at the epidermis, but that the latter is abundantly supplied with nervous filaments. Merkel, Ranvier, Ditlevesen, and others, first demonstrated the fact in lower animals. The filaments terminate by club-shaped extremities. In the human subject, it was shown by Langerhans, Eberth, and Roncet, that the epidermis contained not only numerous nerves, but also they described certain stellate bodies in which the filaments were lost, and which these writers regarded as nerve-cells. The latest contribution upon this topic is from Unna.¹ He refers to a previous paper by Pfitzner, who first discovered in the epidermis of the larvæ of the frog and salamander, at a certain period of development, nerves that terminated, after penetrating the cell-wall of each prickle cell, with small bulbous extremities near the nucleus. Every cell contained two of these terminal filaments. Afterwards the same observation was made in the epidermis of the human subject. Unna, pursuing the investigation, fully confirms the results of his predecessor. His paper is accompanied with photographs, in which the appearances are very clearly exhibited. A striking feature of the appearance is the invariable association in every cell of the terminal bulbs in pairs. They did not appear to be branches of one twig, but usually approached the cell from different directions. It is difficult to see what bearing these researches may have in the future upon the physiology of the peripheral nerves, as well as upon the pathology of cutaneous diseases. They certainly reveal in the epidermis a nervous

¹ Die Nervenendigung in der Menschlichen Haut. Monatshefte f. prak. Derm., Oct., 1882, I., 8.

development hitherto wholly unsuspected. Unquestionably these nerves must play an important part in the pathology of eczema.

The most constant and essential factors in the symptomatology of eczema are sensory disturbance and trophic change in the epidermis. The trophic changes that take place in the derma I regard as secondary and contingent. Impairment of the integrity of the epidermis is the necessary condition of every form and phase of eczema. It, more than any other feature of the disease, distinguishes it from those inflammatory diseases of the skin that owe their origin mainly to vaso-motor disturbance and are situated in the superficial layer of the cutis. In the erythemata, the epidermis is rarely seriously involved, and then only secondarily. The desquamation that occasionally follows is such as is common to all simple inflammations of the skin, and is the result of nutritive impairment in sympathy with the vascular disturbance beneath, but an impairment in no wise corresponding to the degenerative lesions of the epidermis to which eczema gives rise. It is more than probable that this trophic change of the epidermis in eczema is under the influence of the epidermic nerves.

Though there is no positive evidence that the epidermic nerves are related to the sense of touch, there is reason to believe that itching—which is tactile sense perverted—is due to their disorder. Pruritus is a marked feature of such cutaneous diseases as are accompanied by lesions, only when they implicate the mucous layer. In urticaria, the only form of erythematous disease in which there is decided itching, there is a violent invasion of the rete cells by effused serum. Doubtless, also, hyperæsthesia of the nerves has much to do with the itching and, perhaps, also motile disturbance. It is a noticeable fact that in many of the pruriginous diseases, such as prurigo and lichen, the arrectores pili, which extend close to the stratum mucosum, undergo decided hypertrophy. But in those diseases there is also marked implication of the mucous layer of the epidermis. In prurigo, beside great thickening of the rete, the external root-sheath of the hair follicles, which is but a prolongation of the mucous layer of the skin, undergoes marked hyperplasia; and a similar condition prevails in lichen-ruber and planus. In scabies, a disease in which the itching is excessive, the itch-mite inhabits and feeds upon the rete mucosum. In psoriasis, the itching is slight except in the beginning; but it is not claimed that pruritus is necessary to every disease in which the rete is affected. In psoriasis, it appears that the changes that the prickle-cells undergo are not of such a character as to compromise the sensitive nerves. Most of the vesicular diseases are attended with itching when the vesicle is deep-seated. In superficial vesicles, such as the sudamina, where they are contained within the stratum corneum, itching is absent. The deep vesicles of zoster do not generally itch, pruritus

giving place to the greater perversion of pain. In herpes facialis and progenitalis, the itching is marked, and the same is true of pemphigus.

With regard to the pathological anatomy of the cutaneous nerves in eczema, but little is known. Colomiatti¹ found in several instances, both in acute and chronic eczema, the lesions of neuritis. They consisted in segmentation of the medullary substance and in the disappearance of the axis cylinder. The segmentation proceeded till little granules, like fat molecules, were formed. The process extended from the superficial to the deeper layers. The nerves were regenerated as healing took place. Leloir² was unable to confirm these investigations. In the specimens examined by him the lesions did not appear. Marcacci described a case of universal eczema that was associated with lesions of the cervical and cœliac ganglia. There are many other instances on record of a corresponding character showing that eczema may occur in connection with a great variety of nervous lesions. They chiefly serve to indicate the intimate relation of the disease to the nervous system. Doubtless the initial motive of the morbid process—the exciting cause—may be developed from various sources, direct (external) irritation of the epidermis, reflex irritations, central nervous derangement, or diseases of the nerves, either in their continuity or at their periphery. Of greater moment to the practitioner are the predisposing causes, but they will be considered in connection with the subject of internal treatment.

In eczema, then, we have to do with a disease, the main factors of which are a cutaneous inflammation, of a catarrhal character, seated primarily in the mucous layer of the epidermis, which incidentally involves the derma to a greater or less extent, and is accompanied with marked disorder of the tactile sense. Furthermore, it is a disease in which there is ordinarily but little disposition to spontaneous recovery. The obvious therapeutic indications are, first, to allay irritation, and second, to assist repair. The one requires the elimination, so far as possible, of all sources of irritation whether extraneous or inherent, together with protection of the damaged epidermis. The other indicates a resort to such therapeutic stimulants as will combat the tendency to chronicity. Measures of rest and measures of stimulation comprise the whole treatment of eczema. In applying our treatment, two methods of approach are possible, a mediate one and an immediate one; the first by internal medication, the other by topical application. The easy accessibility of the suffering organ in eczema would naturally suggest first the method of direct application—the method which we will first consider.

In the local treatment of eczema, we employ agents that are either

¹ Giorn. ital. delle mal ven. e della pelle, XIV., 3, p. 129.

² Rev. de Sci. Med., No. 38, Apr., 1882.

mechanical, chemical, or dynamic in their action. The agents that act mechanically are chiefly employed for purposes of protection. They answer the same purpose as the simple dressing for a wound. They include various inert powders, lotions, simple ointments, and emollient applications generally. The indications for the different varieties of this class are not precisely identical. As a rule, the highest grade of inflammation, as in the acute erythematous form, is best treated by wet applications—applications that abstract the local heat by evaporation, while at the same time they prevent desiccation of the superficial epidermis, which is usually in a harsh, dry condition that tends to increase the irritability of the subjacent nerves. The lotion may either hold in suspension powdery substances that collect upon the epidermis, and supply a soothing envelope to the part, or in it may be dissolved certain chemical materials that exert a slight modifying effect, such as mild astringents or alkalies. In using lotions, however, it is of importance that the application be continuous. Alternately wetting and drying the inflamed skin is always attended with irritation. The wash is generally improved by the addition of a small quantity of glycerin. Undiluted glycerin is an irritant. Emulsions are also well suited to this stage of the disease. When the inflammation is a little less intense (acute papular eczema), the best applications are the insoluble powders. Between lycopodium, starch-powder, talc, calamine, oxide of zinc, or the like, there is little to choose. It is chiefly essential that the applications should be copious and frequent. The effect is increased by first smearing the skin lightly with cold cream, some soothing emulsion, or glycerin and water, which affords a surface to which the powder will better adhere. A little later, and the period for the use of ointments has arrived. The skin has become rougher and harsher, the cuticle is brittle and ragged, the surface is dotted with scales, crusts, and abrasions. Here and there vesicles appear, or, more commonly, minute punctate excoriations. From this time forth, in the majority of cases, the cure proceeds, under the continuous protection of an appropriate ointment, until such time as the epidermis is sufficiently regenerated to perform its protective function unaided. Such an ointment requires to be perfectly non-irritating; it must be smooth and homogeneous, and entirely free from rancidity; it must not be so greasy as to become easily displaced or, by softening the cuticle too much, render it more vulnerable, but of such a firm consistency as to afford a perfect shelter to the exposed and irritable cutaneous structures, and, at the same time, hinder undue desiccation. It is rare to find any preparation that so perfectly fulfils those requirements as our common zinc ointment. Indeed, for general use, I know of none to compare with it. In the great majority of cases where a protective ointment is indicated, it is

all-sufficient; and rarely is any other needed. Under its shelter and control, stimulation may be effected by certain measures that are resorted to intermittently or, if a more constant stimulus is desired, the ointment may be modified by the addition of various medicaments. But eczema has certain phases to which ointments are not suited. That they should not be begun at a very acute stage of the disease has already been indicated, but there are other circumstances under which their use is contra-indicated. Where a more or less extensive surface is eroded and exudes a copious and ichorous discharge, the effect of all ointments is generally unfavorable. In such a condition, either an astringent wash is indicated, or, better, an absorbent powder. The absorbent effect of the powder may be increased by adding a little gypsum in the proportion of one to four or one to eight, care being taken that no gritty particles are present.

We come now to a class of agents, the action of which is more complex and obscure, agents that act as modifiers of vital action. By far the most important of these are the alkalies. Their value in the treatment of eczema in almost every stage of the malady has long been established. In fact, there is scarcely a form of inflammation to which either the cutaneous or mucous surfaces are subject that is not beneficially affected by their use. Chemistry may partly explain their action, but the inquiry verges upon the domain of vital dynamics. One important feature of their action is the sedative influence they exercise over sensory nerves. No more certain anti-pruritic exists, and no remedy affords greater relief for the heat and burning of an inflamed skin than external alkaline applications. The virtues of the alkaline bath I believe to be rather under than overestimated. Although medicinal agents are probably unable to penetrate the intact cuticle, yet when they are applied over an extensive surface, they gain sufficient access to produce decided effects. Employed over a surface of narrow limits, the alkaline effect is most marked when the corneous layer is abraded and the nervous stratum of the epidermis is exposed. So long as the eczema partakes of an acute character the alkali is used in the form of dilute washes; but later, when pathological products begin to accumulate upon the surface, and are with some difficulty dislodged, its action is promoted by using it in the form of soap. The kind of soap employed should vary with the phase and character of the case. In old chronic cases, where there is a decided thickening and thick laminae of adherent scales are being constantly formed, the stronger potash soaps are indicated,¹ while in cases in which the scales and crusts are thin-

¹For this purpose, either the so-called *Schmierseife* of the Germans may be used; or, better, the olive potash soap, which is sold here under the name of "Sapo Olivæ præparatus," and was first brought into notice by Dr. G. H. Fox.

ner, and the skin less tolerant of severe measures, the milder soda soaps are used, preferably those made with glycerin, which usually contain a relatively small proportion of alkali (Sarg's, Rieger's, or Pear's soaps being the best). In squamous eczema, the so-called "soap treatment," which we owe to Hebra, has no equal. But to be effective, it must be thorough. Of themselves, the frictions would cause useless irritation were they not associated with the removal of a source of greater disturbance. The action in this method of treatment may be partly substitutive, but there is often surprisingly little irritative reaction, and the relief is almost immediate. In squamous eczema, there are almost always vesicles deep down in the rete, imprisoned by the desiccated epidermis or dried secretion above, and, under these circumstances, the epidermic nerves suffer an intense irritation. The purpose of the soap is to thoroughly clear away these irritating pathological products, to evacuate ichorous fluid which has formed in the vesicles, and to bring the liberated alkali in direct contact with the diseased tissue, thereby modifying the vital processes and exerting a direct sedative influence upon the adjacent nerves. Though this, I believe, is the chief purpose of the operation, its stimulant effect doubtless tends to promote absorption, and thus still further assists the reparative effort. It is seldom that a stronger alkali than that contained in soap is required except for very limited application. A strong alkaline solution is less available than the soap, for the reason that its caustic action is less uniformly exerted, acting too deeply where the epidermis is abraded, thus interfering with its adequate use where it is especially needed for the removal of accumulated scales. As a simple caustic, agents that act more superficially are preferable, such as carbolic acid or the nitrate of silver. As a general rule, the nitrate of silver or its solution is most useful in circumscribed forms of moist eczema, in which there is a pyogenic condition.

For the pruritus of eczema, the virtues of simple hot water deserve especial mention. They probably depend upon a twofold action, the first effect of which is to stop the itching by substituting the sense of smarting. The same effect is produced temporarily by violent scratching. The "paræsthesia" of pain prevails over and excludes the "paræsthesia" of pruritus. This, in the case of the hot water, is succeeded by a sedative effect, which is secondary, and the result of a certain local depressant or enervating action that is the equivalent of the general relaxation and exhaustion which follows the full hot bath when too prolonged. In order to insure a continuance of the antipruritic effect of the hot water, it is necessary that the applications should not be stopped too soon.

Carbolic acid is a remedy of great usefulness in eczema. Its action

varies according to the degree of its concentration. In its strongest form, its effect is to annihilate vital action. In a moderately concentrated form (from 1 : 4 to 1 : 8), it annuls local excitement, and produces sedation; while in a dilute form its action corresponds very closely to that of the tarry remedies. The effect of the first form, in which the drug is a caustic, is exceedingly well adapted to the treatment of irritable fissures in eczema, for the reason that little or no inflammatory action is excited by it, while it acts as an anæsthetic to the surrounding nerves. In the second form, carbolic acid has very decided antipruritic virtues. It is adapted to cases in which the region affected is of small extent and pruritus is intense, a notable example of which is eczema of the anus. In the third form, the indications for this remedy are nearly identical with those of tar and its congeners. Where the latter are objectionable, carbolic acid may be used as a succedaneum.

The action of tar in cutaneous diseases is doubtless analogous to that of the terebinthinate and balsamic remedies in diseases of the mucous membranes. Whatever the nature of the action of these remedies may be, there is no question of their power to modify inflamed surfaces. Generally speaking, they exert their salutary effects after the acme of the inflammation has passed; the nerves have lost some of their præternatural irritability, and the condition is one of impaired energy, of relaxation, of congestion more or less passive. It is under these circumstances that this class of remedies is especially indicated. They renovate the vascular tension and check the excessive secretions. In the eczematous inflammation of the skin, the period for commencing the tarry applications appears to be a little more delayed than is the case with regard to the corresponding remedies in inflammation of mucous membranes; perhaps for the reason that in the latter case, when the drug reaches the seat of trouble it has become less irritating, through dilution or modification of its active ingredients. But it is a good rule in eczema, that during the stage of active exudation in the mucous layer, tar is contra-indicated. Its healing virtue is best evinced when the signs of the disease are mostly confined to the corneous layer of the epidermis and the superficial blood-vessels. Desquamation still continues while the papillæ are passively congested. Though this rule applies to tar as generally employed, as well as to the related substances naphthol and thymol, it does not necessarily to all the remedies to which tar is akin. In the benzoated zinc ointment we employ an agent that belongs to the same class of remedies we are considering, the effect of which should not be ignored. Though present in too small quantity to cause any perceptible irritation except in the rarest instances, it is not improbable that it has a certain modifying action. The efficacy of all of these remedies is doubtless largely assisted by their volatility, enabling them readily to penetrate the skin and perform

their appropriate reactions. Our management of these remedies would admit of great improvement. It is doubtful if we avail ourselves of the benefits of which they are capable, except in a very imperfect degree. Increased success in the treatment of eczema may be looked for in the future mainly in the direction of improved methods for making the virtues of this class of therapeutic agents more available at an earlier stage of the disease.

The agents of the narcotic class that occasionally find employment in the local treatment of eczema, as palliatives, require no especial consideration. Their effect is often over-estimated. Unless applied to an abraded surface, the action must be very slight. Certain of them, however, by reason of their volatility (notably camphor), are useful adjuvants in case of pruritus.

The last class of agents to which I would call attention is that of the mercurials. Though sometimes useful at earlier periods of the disease, their chief rôle comes into play at its latest stage—a stage in which the skin is no longer in active inflammation (though a few remaining vesicles need not preclude their use), but suffering in its nutrition, owing to the presence, mostly in the cutis and subcutaneous tissues, of the accumulated products of inflammation. It is in the removal of such products, whether cellular or fibrous, that the potency of mercury as a therapeutic agent is especially exhibited. This property it possesses by virtue of its hostility to all living organisms, attacking those tissues first that have been recently formed and are but imperfectly organized, impairing their vitality and predisposing them to rapid subinvolution and resorption. While this is its peculiar, its pathognomonic effect, it also has, as often employed, a stimulant or substitutive action in common with other irritants, but that the latter is not its sole action is evident from the difference between the effects produced by the mercurials and those of other irritating applications.

An exceedingly useful remedy in the treatment of advanced eczema with decided thickening, is the “impermeable dressing,” more especially the rubber applications. Their effect is to macerate the thickened and desiccated cuticle, which, being removed, enables the deep vesicles to discharge their contents, while at the same time a substitutive inflammation is set up, which, by countervailing the chronic eczematous process temporarily, tends to assist repair. When this artificial inflammation becomes severe, it necessitates the dressing being removed. It causes a new development of papules and vesicles, and sometimes large unilocular bullæ, the higher grade of inflammation induced producing the same effect as a blister or a burn.

I have thus briefly indicated the more important external agents, the value of which in the treatment of eczema has been established by ex-

perience. Though they embrace a wide range in therapeutics, including as they do emollients, sedatives, astringents, irritants, excitants, and alteratives, they are divisible into two classes, corresponding to the two main indications of the disease. To one class belongs the function of protection; while it is the function of the other to assist and direct reparative effort. In the early stages of the disease, before the morbid habit has become confirmed and the natural reparative power is but little impaired, protective measures may suffice unaided to effect a cure; indeed, throughout the whole course of the treatment their assistance is more or less indispensable. They not only prepare the way for the stimulant or modifying agents, but, when the latter come into play, serve to moderate and control their effects. It is upon the proper apportionment of these two opposed but virtually co-operating therapeutic functions that the successful treatment of eczema will mainly depend.

When is it necessary then, to resort to internal medication? The indications that are supposed to require general treatment in eczema may be divided into four sets: (1.) For the relief of internal disorders that affect the skin by reflex irritation; (2.) to remedy general debility or special systemic diseases which are accompanied with defective innervation or innutrition of the skin; (3.) to aid the local resources of repair by the administration of drugs that either act directly upon the skin by selective affinity, or, else, (4.) set up internally a transpositive irritation by means of which a share of the cutaneous excitement is diverted to other organs.

Sometimes an attack of eczema, more particularly when acute, appears to owe its origin to internal causes, for the reason that no unusual source of irritation has affected the skin externally. Oftener eczema is the combined effect of an irritation acting from within and another acting from without. In the latter case the cause is exciting; in the former it is generally predisposing. Reflex irritation of the skin, such as may be excited by disturbances of the digestive or generative functions, rarely suffices alone to cause the disease; but when it is prolonged the cutaneous nerves become so irritable and debilitated that they can no longer tolerate external influences which, under ordinary circumstances, would be insignificant. Likewise with regard to those systemic diseases which are attended with a general debility, such as gout, rheumatism, lithæmia, uræmia, diabetes, and the like, the nutrition of the skin suffers in common with that of the other tissues, and there is developed a predisposition to disease. But why should these remote sources of irritation and these predisposing causes avail to produce eczema only, as they do, in certain individuals? Back of the general predisposition that arises from conditions which affect the health at large, we are compelled to infer the existence of a special cause that determines the cutaneous effect in that limited class of individuals known as eczematous.

According to the French school of dermatology, this special cutaneous susceptibility is attributable to a special dyscrasia. Eczema is necessarily the expression of a systemic malady which, at certain periods and under various influences, becomes intensified, betraying itself in an outbreak of eczema upon the skin. Of this peculiar diathesis "*les dartres*" constitute the sole manifestation and evidence. But is this explanation the only possible one? Is no consideration due the inherent nature of the skin affected, its peculiarities of organization, the measure of its tolerance of irritating influences? Why should not the skins of different individuals differ as much in their constitution and morbid tendencies as do their other organs, their nervous, digestive, pulmonary, or muscular systems? Some people have "weak" eyes; others are predisposed to caries of the teeth; some have feeble digestion or "weak" lungs; others still are "neurotic." Some of these weaknesses evince defects of anatomical structure; in others the defect in organization is less patent, but is betrayed by frequent derangement of function and proneness to disease. So with the eczematous subject. He is by no means necessarily a person whose general health is impaired, though at every departure from health the skin is quick to take offence. How common it is to see well nourished, robust children, in whose general condition not a flaw can be detected, with the single exception of a persistent eczema! It is the skin alone that suffers, and that upon a minimum of provocation. Whatever may have been the original, in- or external, exciting cause, the cutaneous effect is a wholly disproportionate one—such an effect as would only be produced upon an organ capable of but a feeble resistance. Such individuals commonly have dry, harsh, irritable, and itchy skins. Not always, however. The skins of different eczematous subjects differ in the degree of their vulnerability as well as in their disposition to recovery after an eczematous outbreak has occurred.

But why, it will be asked, should the particular disease eczema be such a constant effect? Why not other forms of cutaneous inflammation? For the reason that eczema is the natural and the usual expression of a simple inflammatory action in the epidermis. So soon as an irritation can no longer be tolerated by this tissue, the vitality of the part begins to succumb, and the legitimate outcome is eczema. Its physiognomy is not always the same, and I am not prepared to say that there may not be allotropic forms corresponding to this inflammatory action, depending upon peculiarities of the cutaneous organism in the individual, which diverge so widely from the simple type as to present the features of a different disease. The relations of psoriasis to eczema, or possibly those of other diseases that chiefly implicate the epidermis, would form an interesting subject of study in this connection.

It follows from what has been said that, whatever the predisposing causes

of eczema that may arise in the economy at large, the most essential predisposition inheres in the skin itself. Eczema, then, is essentially a local disease, and the most rational treatment is that which addresses itself most directly to the offending part. By oblique methods, however, we may obtain great assistance which should not be ignored. At the beginning of treatment or when the inflammation is either active or obstinate, the effect of a powerful internal diversion will often so ease the cutaneous excitement as to determine the success of the local treatment. Tonics, regimen, purgatives, diuretics, alkalies, have their appropriate place, and in discreet hands become invaluable adjuvants. I cannot but assign to internal medication, however, a subordinate rank. Eczema has no specific. I know of no salutary effect of which any internal remedy is capable, through a selective affinity for the tissue affected in eczema, that may not more certainly and safely be produced by immediate external medication. Remedies that have such a selective action there doubtless are, but their effect is so conjoined with or conditioned by modifications of the economy at large, which we can neither foresee nor control, that upon the whole this effect becomes of doubtful utility. With regard to certain of these remedies, more especially those of the narcotic class, I believe that they should be mentioned but to be condemned. When obvious derangements exist in the general system or in some internal organ, it is the manifest duty of the physician to address himself to their relief. But unless their influence upon the cutaneous disease is well marked, I should expect comparatively little assistance in this direction. So far as chronic eczema is concerned—that is, the prevailing and the most characteristic form of the disease—in a large proportion of cases the original cause has long ceased to be operative, and though some predisposing influence may still proceed from general conditions that depart more or less from a perfect state of health, the complete relief of such conditions is often impracticable, nor is it by any means necessary to a cure of the eczema. In a majority of the cases, local treatment is well able to cope with the cutaneous disease single-handed.

Diligent search for all sources of morbid influence, whether remote or near, is scientific and praiseworthy, but if led by the preconception that every eczema has an essential internal cause, it will often prove, I am convinced, to be the pursuit of a phantom.

SMALL-POX AND MEASLES.—Wolberg reports a case in which a variculous eruption appeared on the 23d of June, followed by an outbreak of measles on the 6th of July. The patient, an eight-year-old little girl, recovered, and was discharged from the hospital on the 19th of July.—*Berl. Klin. Woch.*, Nov. 20, 1882.

REPORT OF A CASE OF PELLAGRA.

BY

S. SHERWELL, M.D.,

Clin. Lecturer on Dis. of Skin, Long Island Hosp. Med. Coll.

TOMMASO CAPRIO, a seaman, æt. 35, of middle stature, and apparently robust and well nourished, native of the country near Genoa, and belonging to an Italian barque of that port, entered Long Island College Hospital June 5, 1882. He had first noticed the specific lesion for which he came under treatment, about four months prior to that date; his general health had not then been entirely good for some time, feelings of malaise, etc.

The eruption appeared first in the frontal region, between and somewhat above the line of the eyebrows, and was from the beginning, according to his statement, a slightly raised erythematous patch.

I was requested by the visiting surgeon, Dr. G. H. Atkinson, to examine the case, and did so, in company with Dr. A. H. Brown, resident surgeon, in whose service the ward was, at or about first week of July. The disease at that time had spread over about one-half of forehead, the whole of the nose (the internal aspect of which was also invaded, the alæ being much thickened), both cheeks, and a large portion of the upper part of face, and the whole of right auricle. The invasive progress had been steady and continuous; the parts first suffering being the more prominent portions of face, as for instance, those overlying the zygomatic processes being attacked early, in a direct ratio as to grade and time, the parts first invaded having the worst appearance.

The aspect "*in toto*" was that of an erythematous eczema of severest form with some exceptional features, the infiltration of tissue being extraordinary, and it was accordingly so diagnosed; and an alkaline lotion, very mildly carbolyzed and containing a small amount of glycerin and alcohol, advised. At a later date, I saw him again with Dr. B. Patient had derived no benefit from application or other treatment; I then took more notice of his general condition, and, in answer to queries, found that he was in a condition of great torpor and hebetude, physical and mental; cried easily, and appeared depressed and stupid. A dry and scaly collection of epidermis and exudative deposits lay on and over the larger portion of invaded tissues, which could be partially lifted off, showing on the under surface of the scab the papilla-like projections, and in the skin itself the pit-like depressions, so common in lupus erythematosus; and now, in view of the general erythematous character of the lesion, I was led to express my opinion that it was a case of anomalous erythematous lupus, with the invasion going on much more rapidly than we expect in cases of the kind.

About fourteen days later (I saw him probably two or three times more during the balance of the month) the eruption had spread over the entire face and neck, down to the region in which the shirt of a sailor is open, with very marked limitation at that point.

In the beginning of August, the same bright, and in some places

purplish, spots, slightly infiltrated in character, made their appearance on the hands and extensor surfaces of forearms; the eruption now encroached somewhat on breast, and lost in the upper portions its purely erythematous character, taking up the characteristics of eruption on the face, dry, scaly, and superficially fissured. The eruption also about this time appeared in a more isolated way, and less marked in character over the anterior surfaces of lower portions of the inferior extremities, the surfaces in fact ordinarily, or occasionally at least, exposed to the sun's rays in the occupation of seamen.

I was much puzzled at this time to make a diagnosis, as I had never seen anything exactly similar, and yet as it seemed to me Erythematous eczema and *E. lupus* must certainly be excluded, nor could the eruption be purpuric. One prominent symptom of erythematous eczema had never been present, viz., pruritus; the only feelings being, as far as I could ascertain (the patient being a foreigner, and an interpreter not always present), a slight sense of pain and stiffness, less marked even as to these than seemed possible.

The patches mentioned, as they grew larger, coalesced; and in places, both on the upper and lower extremities, small bullæ were formed, which, in the later course, were quite a marked feature of the disease. Another striking and contemporaneous symptom was a number of rhagades about backs of the hands.

About August 14, Dr. Atkinson put him under a course of decided antisyphilitic treatment as a tentative effort, in view presumably of the protean character of syphilis and the well-known exposure of seamen to this form of trouble; this was not known to me at the time, in fact my suggestions for treatment had been almost or entirely local in character, and, I may add, totally without effect. Whether as a result of this course of treatment or not, the disease which, heretofore, under all treatment, had been progressing every way unfavorably but slowly, now took a very much more rapid downward course. The eruption which had been in most places of a comparatively bright erythematous hue, except in the oldest of attacked tissues, became in places quite livid and purple, though the difference even then between its character and purpuric staining was manifest; the rhagades became deeper, the bullæ larger, some as large as a thumb-nail appeared in various places, as on the backs of the hands and feet, extensor surface of the forearm, etc.

On August 19-20 held formal consultation with Drs. Atkinson and Brown, my previous visits having been only informal and at Dr. A.'s request, and expressed my reasons at this time for disbelief in the syphilitic character of the manifestations, in which also Dr. A. concurred, and gave my opinion that it was a case of pellagra, and stimulants, quinine, tinct. nux vomica, tinct. ferri chlor., etc., were ordered. Some slight improvement for a time seemed to result. On one or two subsequent occasions, I saw him again with Dr. Atkinson, and each occasion fortified me in the diagnosis arrived at, both from consultation of authorities and a more minutely detailed "*vica voce*" examination of the man himself, so that I became positive. At this time, I took occasion, it being such a rare form of disease in this country, personally and by letter to acquaint several of my dermatological friends in New York with the facts, and ask their inspection of case, but it is to be regretted none found time.

The patient's condition as to mind, etc., had grown worse "*pari*

passu " with the invasion of the disease. I incline to the belief that the destructive metamorphic action of the hydrarg. and potass. iod. accelerated the march, short though the time during which it was employed. He died on the 10th of September of exhaustion.

During the earlier portion of the last two weeks of his illness, the distal extremities, both upper and lower, took on in parts a dry gangrenous appearance, which in the later stages became positive as to toes.

Another peculiar feature during the last fortnight was that the eruption became pretty general; no portion, even of trunk, being entirely free. These eruptions ran a more rapid course, they seemed to be distinct sphacelations, superficial in character, and of the most varying extent; no distinct reason, save the character of the disease itself, could be urged to account for this sloughing, such as pressure, etc.; in fact, on nates, small of back, and spinal region generally, the lesions were fewer in number and extent, and in every way less marked, thus proving that decubitus was not answerable as a causative agent.

Remarks.

In the above history, I have had mostly to rely on personal observation and recollection of Dr. Brown and self, and on ordinary routine hospital case-book. I had taken no notes, my relation to the case, at first at least, having been only a matter of courtesy and kindness from Dr. Atkinson. I regret that none of my dermatological colleagues in New York were able to see it, as I believe it to have been a typical exemplar of a disease that I do not recollect of ever having seen recorded even if observed in this country.

A few facts in the personal history of the man, as bearing on etiology, may be added:

I learned from Dr. B. that an interpreter had informed him that for some time (months, I think) previous to shipping, the man had been living in his native place in the interior of the province; that there was no family history bearing on case; that he had not felt quite well for some time previous to sailing; that the disease (*i. e.*, the first manifestation on forehead) broke out within a very short time after leaving port; that the voyage was on a southerly course from that to this port. Another interesting fact in relation to causation is the mode of life peculiar, it would seem, to Italian seamen on these small vessels, and that is, that they do not have a regular or common mess, but it is the custom for each sailor to bring on board his own provisions of maccaroni, maize or rye meal, rice, etc. It is possible or to be supposed that in this case he in all probability procured his supplies from his own home, the quality of which would be about the same as those to which he had been accustomed there. This I would urge is important, in view of the generally received theory of causation by ingestion of poor and blighted cereals, ergoted maize and rye, smutty and mildewed wheat, meal, etc. All who have

visited Southern Europe must know that cereals, vegetables, and fruits constitute all or nearly all the solid foods of the poorer classes.

I think it has been generally noted, too, that pellagra is vastly more common in the lower portion of the upper third of Italy, that is to say, in the provinces including Lombardy and Genoa, from whence it will be noticed this man comes.

Authorities state that this disease also can be shown statistically to have been more prevalent in the months and year succeeding wet harvests, in which the curing of the cereals necessarily suffers.

NOTE CONCERNING A CONVENIENT METHOD OF APPLYING LOTIONS TO THE HAIRY SCALP.

BY

L. DUNCAN BULKLEY, A.M., M.D.,

New York.

IN applying lotions to the hairy scalp, especially those used to stimulate the growth of hair already of some length and thickness, it is often very difficult to insure that a sufficient quantity reaches the scalp itself and is thoroughly rubbed in. When this can be done by an attendant the difficulties are less, but when the patient attempts to pour it on the head, either from the mouth of a bottle or by means of an opening in the cork, in the manner in which barbers apply liquids, there is always more or less uncertainty as to whether the lotion reaches the desired part, and as to the quantity applied. To attempt to pour it on the palm and then to apply it to the scalp is almost useless, inasmuch as the larger portion falls upon the hairs themselves, and the scalp is dampened only after the hair is thoroughly soaked, which is not only unpleasant but involves a useless waste of the remedy.

For this purpose I have been employing, for several months past, the ordinary medicine dropper, or better yet, the small affair which is commonly used for filling the stylographic pen. Both these are composed of a short glass tube, drawn to a small opening at one end, and mounted at the other end with a small rubber cap expanded into a bulb. For those not familiar with the little instrument, the following cut (drawn full size), will give an idea of its construction.

The manner of its use is very simple. The lotion, being thoroughly shaken, is drawn up into the tube by alternate compression and expansion of the rubber cap, and then the point is inserted beneath the hair,

and the fluid is ejected in the desired place, while the fingers of the other hand are used at the same time to rub it well into the scalp at the roots of the hairs. By this means the skin may be thoroughly dampened with



a comparatively small amount of the lotion, and all the necessary effects are produced without making the hair unpleasantly wet. The many patients who have used this method all express themselves as greatly pleased with it.

Society Transactions.

NEW YORK DERMATOLOGICAL SOCIETY.

132D REGULAR MEETING, DEC. 26, 1882.

DR. E. B. BRONSON, *President, in the Chair.*

PRESENTATION OF CASES.

DR. ROBINSON exhibited a

CASE FOR DIAGNOSIS.

The patient had been shown to the Society six months ago, when the disease was pronounced to be syphilis. The patient, a woman forty-nine years old, has had five miscarriages, the last three years ago. She has had the present disease five years, the lesions coming and going. She now has three patches of it, the largest at about the middle of the outer aspect of the right forearm, a second over the back of the left wrist, and a third, the smallest, just above the right elbow, on the extensor surface of the limb. Scars from former lesions are also present on different parts of the body, although the lesions do not always leave cicatrices. The largest patch is of an irregularly triangular shape, surrounded by a red areola, and is covered with a blackish-yellow scab, upon removing a portion of which no destruction of tissue is found to have taken place under it. The spot never grows any larger. It began as a dermatitis in the shape of a small pustule, which spread peripherically, became covered with sero-purulent matter, which dried and formed the scab. The patient for some time took one drachm of the iodide of potassium daily, but without benefit.

DR. KEYES said that at first sight the lesions suggested syphilis, but a more careful examination showed that they differed from syphilides in several respects, viz., the crusts are too red and friable, and not green enough, they are not set deeply enough in the skin, the borders of the patches are not livid enough, and show no pigmentation, and there is too little scarring at the site of the old lesions. Another point of difference from syphilis is that the lesions have persisted too long in one form. He had, however, recently had a case under observation which presented identical lesions, of undoubted syphilitic origin, which did not begin to improve until the patient took sixty grains of iodide of potassium three times a day. He thought the present case one of undoubted syphilis, and that the patient had not taken enough iodide of potassium to thoroughly test its power.

DR. FOX would make a diagnosis of syphilis in spite of the atypical appearances presented by the lesions. He would advise the administration of cod-liver oil for a time, believing that, after the patient's general health had improved under this agent, the "mixed treatment" would cure the disease.

DR. SHERWELL alluded to a case at present under his care which was very similar to this one. The patient, a boy ten years old, has been nearly well once, but has recently had a relapse, the lesions re-appearing on the same surfaces as well as on others. He considered that case one of pemphigus. In this case, if the disease were syphilis, we should have had graver lesions by this time. He would call the case one of pemphigus, of a lingering type.

DR. BULKLEY could see no reason why the case should not be pronounced one of syphilis. With regard to the persistence of one particular variety of lesion in the case, he recalled to mind a patient whom he had exhibited to the Society, where the same lesions had been present for more than a year in the same spots. As regards treatment, he felt confident that the steady use of mercury and iodide of potassium, combined with iron and nux vomica, and the infusion of bark would cure the disease in a month. For local use, he would advise a mild calamine and zinc ointment, with a small quantity of carbolic acid added.

DR. MORROW thought the case one of syphilis, the history of five miscarriages pointing unmistakably in that direction. This diagnosis could also be reached by exclusion, there being no other disease which could present such appearances.

DR. PIFFARD suggested iodized starch in teaspoonful doses as likely to prove of service in the case.

DR. BRONSON said that, as a rule, the older the syphilis the less typical are the lesions of the disease. He thought that this fact would account for the unusual characteristics of the manifestations in this case.

DR. ROBINSON said that he did not consider the case one of syphilitic rupia, for, in that affection the crusts are formed in consequence of tissue necrosis. In this case there is no destruction of tissue, the primary lesion being a small pustule, which lasts four or five months, being seated upon a red inflamed surface. The small cicatrices seen at the sites of old lesions he regarded as similar to those that occur in some cases of impetigo of a severe character.

The patient had never had "the mixed treatment," but had at first taken iodide of potassium. Under this she at first improved, but afterwards grew worse. Mercury, with iron and nux vomica, was then substituted, but no improvement taking place, arsenic was given. Equal parts of mercurial ointment and vaseline were used locally, bound on the parts, and also without benefit.

DR. PIFFARD exhibited a case of

LEUCODERMA IN A NEGRO BOY.

The subject, John W. Nash, nine years old, was born in Philadelphia, of perfectly black parents. When he was between one and two years old, white spots formed in the right popliteal region. Since then others have appeared at various points, and they have gradually increased in number and size up to the present time. He is a healthy, well-built boy, with other functions normal. The disease is still on the increase, small spots forming and running together. None of the white spots have ever turned black again.

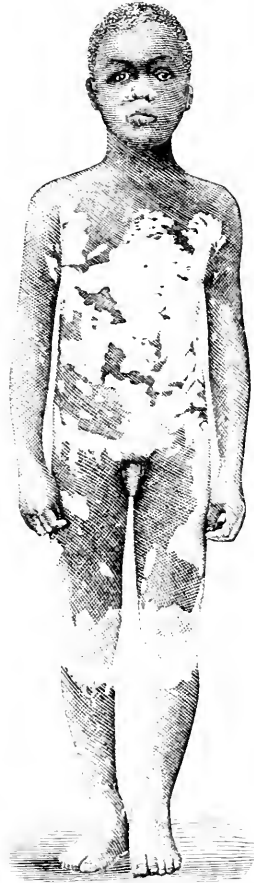
DR. MORROW said that the leucoderma is here more extensive than in any case he had ever seen. He would like to ask the Society whether, in their opinion, vitiligo might not be of neurotic origin, and cited the recently published investigations of Leloir, who had found changes in peripheral nerves in this disease.

DR. FOX called attention to the statement so often made in text-books that the extending patch of the disease always has a convex border, and said that it was not confirmed by either this or the case of leucoderma shown at the preceding meeting, in both of which the spreading white spots have often concave borders.

DR. PIFFARD said that the case differed from ordinary vitiligo in the absence of a hyper-pigmented border to the patches. It is an interesting question, from an ethnological stand-point, whether or not these two boys are the children of pure negroes. Careful inquiry had convinced him that they were both the children

of pure negroes, not mulattoes. Such cases as these are not very rare, not rarer than cases of vitiligo in whites. On the latter, the patches often resume their normal color at certain seasons, which has not occurred in the present instance. In this boy some of the hairs are white, but many remain black on the white patches on the scalp. In his experience in those cases in which the patches come and go, the loss of pigment occurs in summer, and the resumption in winter. He alluded to the fact that he had obtained good results in vitiligo from the use of the burning glass.

Dr. FOX said that the resumption of pigment was generally believed to occur



only in the so-called "partial leucoderma," cases in which the skin is mottled, not absolutely white.

Dr. BRONSON had noticed that, in summer, the pigmented portions of the skin become deeper in color, while no apparent change occurs in the non-pigmented spots.

Dr. FOX's experience had been just the reverse of this.

Dr. MORROW was of the opinion that hyperchromia is just as essential a part of vitiligo as achromia.

Dr. TAYLOR spoke of a piebald negro man whom he had seen, in whose case there was no increase of pigmentation in the edges around the spots.

DR. MORROW exhibited a case of

CHANCRE ON THE CHIN.

The patient, a man, was first seen four weeks ago, at which time there was an indurated crateriform, typical chancre on the front of the chin, just below the free border of the lips. The patient ascribed it to a cut from a razor in a barber-shop. He has now a general roseola (the chancre having healed), and on the dorsum of the penis, about one inch above the corona glandis, is a small circular non indurated erosion, with a reddish-white base, covered with small granulations secreting a small quantity of thin fluid. This has been there three weeks.

DR. BULKLEY considered the lesion on the penis a chancroid.

DR. KEYES said it looked to him like a moist papule, or mucous patch.

DR. TAYLOR said that he had seen only one other case of chancre situated on the chin.

DR. SHERWELL exhibited

A CASE OF ATROPHY OF THE SKIN.

W. C., nine years old, male; born in this country. There was no family history of importance. The mother had malaria at his birth, and for some time before. The boy's teeth resemble somewhat those generally called after Hutchinson. He was first seen six years ago, when he was exhibited to this Society. The lesions were then the same as at present, but less in degree, and confined to the face. The diagnosis was then made of *macule et striae atrophice*, which was concurred in by most of the members. He (S.) desired to point out the resemblance the disease now bore to macular leprosy. When he first exhibited the case, five years ago, the lesions were then confined to the face, were pigmented, and often ulcerated. By day-light, the eruption has a decided fawn color. There is now on the back of the right hand a dry red patch, which was originally the seat of a pemphigus-like eruption, and there are one or two similar smaller patches on the face. The only lesions are solid papular elevations, which afterwards atrophy. The temperature of the body seems subnormal, and the tongue is quite cold. Itching is often a prominent symptom. On some of the atrophic spots, small hairs are seen. The tongue is covered with white spots, and is so much thickened that it cannot be protruded beyond the lips. There are also patches on the epiglottis. The appetite is very capricious.

DR. TAYLOR alluded to a paper, which he published in 1876, on a case of "Idiopathic Localized Partial Atrophy of the Skin." That patient had scattered all over his limbs and body (not on the face) elevated oval or round yellow patches, from the size of a pea to half an inch in diameter. These elevations could be picked off, leaving a pearly glossy surface. From their under surfaces, fine processes projected, which had extended down into the hair follicles. The latter were so much dilated that a pin introduced into them would stand upright. He regarded the present case as an illustration of that disease, although in his case the lesions were less uniform than in this.

DR. BULKLEY said that he had seen one case of multiple diffuse atrophy of the skin in a boy nine years old, but without the inflammatory red spots which are here and there visible in this case.

DR. MORROW was of the opinion that there was a neurotic element underlying this case. He thought the term hypertrophy should be substituted for atrophy in designating the disease.

DR. PIFFARD stated that fifteen years ago but little attention was paid to atrophic conditions. Damon was the first, he believed, to show that atrophy is often preceded by hyperplasia. He himself had shown a girl to the Society some years ago, in whom there were prominent ridges on the limbs, which later were succeeded by furrows.

DR. FOX exhibited

A CASE OF LUPUS ERYTHEMATOSUS

in order to illustrate the effects of an application that he had used with great benefit in four other cases of the disease.

The mixture was composed of:

Chrysarobin.....	15 parts.
Salicylic acid ...	10 "
Calamine.....	5 "
Ether.....	10 "
Flexible collodion	60 "

To be painted upon the diseased patches. Salicylic acid has a decided effect upon the epidermis, and chrysarobin upon cellular infiltration of the skin, and he hoped by combining them to obtain great benefit in the treatment of this disease. He had made only one application in this case, and hoped to present the patient a month later, to illustrate the effects of the method.

DR. BULKLEY exhibited a case of

PSORIASIS OF THE PALMS.

The patient, a man of twenty-five years, had an eruption of acute general guttate psoriasis of five weeks' standing, the lesions being of a bright-red color, but slightly scaly, and occupying the whole body. He, as well as his two brothers, has had an ichthyotic condition of the skin for years. On both palms are a few small, faint, slightly scaly, not thickened patches, which seem to be the direct continuation of the unmistakably psoriatic patches which extend down to the beginning of the palms.

DR. TAYLOR could not regard the spots on the palms as lesions of psoriasis.

DR. PIFFARD was of the same opinion.

DR. FOX thought the palmar patches in this case by no means typical, although he had seen one other case in which there were undoubted psoriatic spots on the palms.

DR. SHERWELL said that, although he had hitherto always denied the existence of palmar psoriasis, he was almost convinced of his error by this case.

DR. ROBINSON had no doubt of the psoriatic nature of the palmar patches in this case.

DR. MORROW was confident that, without seeing the body of the patient, no one would ever suspect psoriasis from the appearance of the patches on the palms, and he was by no means convinced that they were of that nature.

DR. BRONSON thought the case a beautiful illustration of the susceptibility of the palms to psoriasis, in view of the well-marked character of the disease on other parts of the body.

DR. PIFFARD said that the accentuation of the lines of the palms inclined him to the belief that the lesions of that part were rather of an eczematous than of a psoriatic nature.

DR. TAYLOR exhibited a case of

CHRONIC ERYTHEMA OF THE FACE.

The patient, a healthy adult of temperate habits, a roofer by occupation, has had for four years an erythema of the face and scalp, attended with a farinaceous desquamation. The skin never crusts, and is never moist, and is soft and flexible. The face becomes of a deep, livid-red when the patient drinks liquor, and the affection is usually worse in cold weather.

DR. ROBINSON thought the case one of chronic hyperæmia of the face, which affection he had always found very hard to cure.

DRS. FOX and PIFFARD thought it a case of mild erythematous eczema.

DR. BRONSON coincided with this view, and said that he had always found the disease very obstinate. He had recently had a case in which the disease was confined to the hairy parts of the face, which did not yield to treatment until he practised epilation.

DR. TAYLOR differed from all those who had pronounced the disease eczema. He considered it simply a chronic engorgement of the blood-vessels, due probably to the constant irritation to which the skin was exposed by the man's occupation. All general treatment directed to the secretions and excretions had failed to relieve the condition.

CLINICAL SOCIETY OF LONDON.

Meeting of November 24, 1882.

J. LISTER, ESQ., F.R.S., *President, in the Chair.*

DR. CAVAFY read a paper on

SYMMETRICAL CONGESTIVE MOTTLING OF THE SKIN.

In this paper, two cases of a curious affection of the blood-vessels of the skin are described. The first was a young woman, aged twenty-two, shown to the Society, who was first seen in March, 1882, when the condition had existed for three years. It began as a reddish mottling of the left shoulder, which gradually spread down the arm, and soon afterwards appeared on the right arm, the cheeks, and both thighs, gradually increasing in intensity. At the date of her first visit the skin of both cheeks was mottled with blotches and irregular rings and streaks of a bluish-red color, most marked on the right side, not prominent, and covered by normal epidermis. Singular, dull, bluish-red maculæ and irregularly confluent blotches and streaks, forming reticulated, annular, and gyrate figures, occupied the exterior surfaces of both arms and forearms and the backs of the hands, being especially distinct over the left wrist. The front and outer surface of both thighs near the knees was similarly mottled, but in a much less degree. The blotches and streaks were not sharply circumscribed, and disappeared completely on pressure, leaving in some spots a delicate fawn-colored pigmentation. The marking also disappeared from the arms when they were held up, and returned when they were allowed to hang down. The neighboring skin was normal in all respects, and the general health perfectly good. The girl had rheumatic fever a year before the mottling commenced, but the heart was unaffected. The only departure from perfect health was a liability to "dead fingers" and occasional dyspepsia. She continued to attend for a month, with no change in the state of the skin. The markings were always intensified by cold; they never completely disappeared, and were throughout unaccompanied by pain, numbness, tingling, or any abnormal sensation. She is still in the same condition. The second patient, also shown to the Society, is a healthy young woman, aged twenty-one, who has been under observation since August, and in whom the affection has existed eighteen months. It began over the ankles, and gradually spread to the legs and thighs. Twelve months later, the arms became affected, and quite recently blotching has begun on the waist; the face has remained free. The mottling is an almost exact counterpart of that in the first case; but more extensive and of a deeper bluish-red color over both legs and the front of the thighs, especially near the knees. It

is situated on the exterior surfaces chiefly, but also extends slightly over the flexor sides. The condition above described was only due to venous stasis or passive congestion of the skin, and appears to be an exaggeration of the marbling of the skin often seen on the skins of children and young persons after exposure to cold; but in the above cases, although cold intensifies the marbling, the congestion remains more or less evident at all times. It is probably due to a vaso-motor neurosis, but the share taken in its production by arteries and veins is not easy to apportion. The affection appears to be quite harmless, and has not led to any changes except pigmentation, and that only slightly; but the disfigurement, especially when the face is attacked, is considerable. The treatment employed has not influenced the condition in any way.

DR. S. MACKENZIE said the cases were interesting and rare, such a condition seldom being so marked and permanent; and Dr. Cavafy's explanation of it was probably correct. The cases had a superficial resemblance to similar conditions due to direct exposure to heat, as from much standing before a fire. A condition of vaso-motor neurosis of the extremities has been described by Weir Mitchell of which Dr. Mackenzie had seen one case; but this differs materially from these present cases.

DR. GLOVER asked if the effect of a bandage had been tried. He was much struck by the good effect of such a measure in a case of long-standing purpura of the legs, where the application of an elastic stocking resulted in a cure.

THE PRESIDENT alluded to the symmetrical character of the mottling, proving it to be due to a neurotic origin.

DR. CAVAFY, in reply, said that the pigmentation, due to exposure to a fire, was excluded by the fact that the color could be pressed out of the part, and that neither patient had been so exposed; further, the mottling in the present cases is diminished by heat. The vaso-motor neurosis of Weir Mitchell, of which a case was brought before this Society by Dr. A. Sturge, is different. The closest alliance was, perhaps, to local asphyxia, which may lead to symmetrical gangrene (Reynaud). The present cases might be a minor degree of that condition. Dr. Glover's suggestion was only applicable to the extremities.—*Lancet*, Dec. 2, 1882.

Reviews.

THE LAWS OF LIFE AND THEIR RELATION TO DISEASES OF THE SKIN. By J. L. MILTON. London, 1882: Chatto & Windus.

MILTON, long and favorably known as a writer on cutaneous and venereal diseases, here gives us a monograph of one hundred and fifty pages, devoted to a theoretical consideration of the laws that regulate the vital power in its relation to the various functions of the body. His chief theorems he states as follows: 1. "The first proposition is that excess in the performance of one function, or more than one, tends to induce deficient action in other organs; thus in some measure proving that the power, which sets in motion and controls the actions of the human frame, is limited in amount, and that it is a constant quantity as regards the whole, and a varying one as concerns particulars, on the principle of thrift.

2. "The second is that this varying quantity of vital power in different parts is, in some measure, the key to a right interpretation of the phenomena of life."

These propositions he endeavors to sustain by numerous examples drawn from pathology, including several of the morbid processes affecting the skin.

The little book is, on the whole, an interesting and ingenious speculation concerning the unknowable, a good book for a leisure hour.

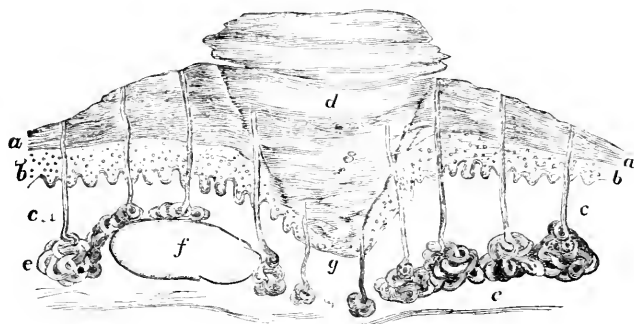
LEHRBUCH DER HAUTKRANKHEITEN. VON DR. GUSTAV BEHREND. Zweite Auflage. Berlin, 1883. Hirschwald.

THE first edition of this work was a small manual readily slipping into the pocket. The present second edition, however, has bloomed into a royal octavo of over six hundred pages, ranking with the works of Neumann and Kaposi, both in size and quality, and as an exponent of modern German dermatology. The general topics are treated in the usual order, viz.: anatomy, physiology, morphology of the lesions, diagnosis, etiology, and treatment. The three former are briefly but justly considered, but the three latter receive but scant attention in proportion to their importance. It is especially as regards the last that the work appears to be weak. Of internal medicaments but three seem to be worthy of the author's attention, namely, arsenic, mercury, and iodine, and their preparations. Of external therapeutics he writes more fully, mentioning water, soap, sulphur, tar, caustics, and mechanical measures. These appear to constitute his armamentarium therapeuticum with, in special cases, occasional reference to cod-liver oil, iron, and quinine: while to many drugs that in French, English, and American hands have yielded most satisfactory and positive results no allusion is made.

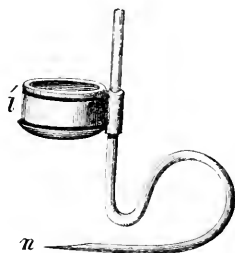
The classification adopted is the anatomo-pathological one of Hebra slightly modified.

When we come to the descriptions of the individual diseases, we discover the real strength of the author, who, in common with his German colleagues, has certainly given us far better descriptions and typical pictures of cutaneous diseases than will be found in the literature of any other nation. The superficial aspects and the morphological relations of the different lesions have unquestionably been better studied in Germany than elsewhere, and the result of this study is indelibly impressed, not only on the literature of that country, but on the dermatological literature of the world, and this is due in great measure to the example and influence of the late Prof. Hebra. If we go beneath the surface and inquire into the structural changes that occur within the cutaneous tissues, we will find that the field was first, and has been most thoroughly explored by our Teutonic confrères, and the knowledge gained in this direction is concisely and admirably put forth by our present author. The questions of etiology, the relations of the various affections to each other, and to pre-existing morbid changes in other parts of the body are not so well worked out; and when we come to the special therapeutics of the individual diseases, we are disappointed at the apparent dearth of resource. Methods of treatment that are well known in England and this country, and concerning which there can be no doubt as to their efficacy, are unmentioned, while some others are simply alluded to as inert. As an example, the treatment of pemphigus may be cited. The author regards internal treatment, including arsenic, as useless, and offers nothing but palliative measures, baths, etc. which certainly in no wise prevent the continuance of the disease. Why arsenic, which, in the hands of English and American dermatologists, has proved so efficacious in checking this disease, should be regarded as useless in Germany, we cannot understand, unless it is that German surgeons, sceptical as to the usefulness of internal treatment generally, have failed to give it a proper trial. *Per contra*, we find various kinds of external treatment recommended that even hospital patients in this country would barely submit to, and which, in private practice, would be utterly impracticable. The scope of the work includes not only the commoner affections, but also the rarer, exotic, and little-known diseases, and, with the exception of the therapeutical portions, may be regarded as one of the best treatises that we have. It is well illustrated with woodcuts, some of which

have done duty before, but many of them are new. The anatomy of the common corn (*clavus*) is well shown at page 327 in the accompanying illustration, exhibiting at *a* the stratum corneum, at *b* the stratum Malpighii, at *c* the corium, at *d*



the corn itself, at *e* sweat glands, at *g* the atrophied papillæ and strat. Malpig., and at *f* a newly-formed mucous bursa, which in a measure may be regarded as a protective organ. A glance at the cut shows why it is that the ordinary treatment of these pests is usually so inefficient. At page 517 we have an illustration



of a very ingenious little instrument by Bergh, intended to aid in the search for and facilitate the extraction of the itch-mite. It consists of a flat curved needle, to which a small lens is attached.

On the whole, Behrend has given us a most excellent treatise, and one that we can cordially recommend to all capable of reading it in the original.

Selections.

NERVE-ALTERATIONS IN LEPRA ANÆSTHETICA.

G. and F. E. HOGGAN, in the March number of *Monatsh. f. prakt. Dermatologie*, announce their intention of publishing, in the course of the present summer, a complete treatise on the clinical and histological changes in the nervous system

resulting from the anæsthetic variety of lepra. In the mean time, they present the following summary of their principal conclusions:

Contrary to generally received opinions, we locate the primary lesion in this disease neither at the central nor the peripheral termination of the nerves, but in the course of the nerve-fibres themselves. The so-called "lepra-cells," which are nothing but altered leucocytes, are found in those parts of the bodily surface which are exposed to the air, immediately outside the nerves and capillaries, and particularly in the neighborhood of the superficial nerves, as, *e. g.*, the ulnar nerve in the region of the elbow. These lepra-cells are so thickly massed together in such parts, that they form what may be called tumors among and between the nerve-bundles (funiculi), which press with ever-increasing force upon the nerves. The latter are in this way as completely destroyed downwards from the point of pressure, as if they were squeezed mechanically. This effect, however, is brought about so slowly, that while some nerve-fibrils are undergoing degenerations, others, already destroyed, are being reproduced; and both processes are found so mingled in one and the same funiculus, that only the practised eye of an inquirer specially occupied with such studies can succeed in completely differentiating them.

These processes of degeneration and reproduction appear to have nothing specific in them; they are not distinguishable from the results of experimental lesions, and where such a distinction apparently exists, it probably arises from imperfect observations.

When a nerve (as the ulnar in the elbow-region) is thus disorganized, all the nerve-structures beneath the point of pressure are destroyed at the same time, as, for example, the nerve-fibres and nerve terminations in the Pacinian corpuscles, or those of Meissner, in the muscles, and in the sub-epidermic and intra-epidermic marrowless nerves. The terminal organs are, however, the first to be destroyed, after the lapse of many years, and the nerve terminations belonging to them consequently survive for a still longer period. In one case they found the Pacinian corpuscles quite intact, fifteen years after their nerves had passed away. The same is the case with the corpuscles of Meissner, which, however, disappear long before those of Pacini, since they yield to a twofold process of destruction and of vacuolation of their component cells.

Degeneration of the small muscles of the hand follows the destruction of their motor nerves, and, as a reaction from the peripheral degeneration, an ascending degeneration of the nerve-fibres even into the spinal marrow sometimes results. At the same time, the cells of the motor nerves may likewise degenerate. In neither of our first two cases was atrophy of the cells of the spinal marrow apparent, but in one of them they could trace the degeneration of the axis-cylinder even to the roots of the brachial plexus. These comprise all the alterations to be looked for in the central nervous system, as consequences of lepra.

While, therefore, the nerve-terminations in the Pacinian and Meissner's corpuscles may undergo disorganization at the very outset of the disease, they may also remain uninjured, even though the nerves of the back of the hand be completely destroyed, as happened in one of their cases—another evidence that the destruction of the peripheral terminations is entirely owing to the primary lesion of the nerve-fibres being accidentally situated on the middle portion of their course. The non-medullated nerve-fibrils undergo the same alterations as from experimental lesions.

When the axis-cylinder is ruptured at the point of pressure, its two ends retract spirally for the length of two or three interannular segments. The periph-

SELECTIONS.

eral portion divides again into smaller fragments which perish, and are re-absorbed in the shape of granular balls; the central termination, however, when reproduced, extends itself as a very fine thread, and pierces straight through the newly-formed segments. In their opinion, all nerve-alterations found in lepra can be traced back to imperfect vitality of the wandering or embryonic cells, and these latter undergo a process of degeneration almost identical with that which they have already spoken of and demonstrated as occurring in the protoplasm of the degenerated fat-cells in the last stage of the resorption. These cells, although containing numerous micrococci and bacilli, have, as we believe, no specific poisonous effect upon the nerves or other organs. Evidence of this is furnished by one of their cases, in which all tactile corpuscles had remained unaltered, although they were able to trace in these bodies hundreds of separated nerve-fibres which, for a length of about two interannular segments, passed through masses of so-called lepra-cells, and yet showed no alteration whatever. If the bacilli exercised a toxic effect in general, surely such isolated, unprotected, medullated nerve-fibres could not possibly resist it during immediate and prolonged contact.

INDICATIONS FOR AND MODES OF ADMINISTERING NAPHTHOL IN SKIN DISEASES.

PROF. M. KAPOSI, in a contribution under this title to the *Wien. Med. Woch.* July 29, 1882, furnishes a tabular statement of the cases treated with naphthol at his dermatological clinic, from April, 1881, to the end of March, 1882. They are enumerated under the names of seventeen distinct cutaneous diseases, and amount in the aggregate to 710; of which 454 were cases of scabies. Adding cases which occurred in the out-door department of the clinic and in his private practice, Prof. K. claims to have administered naphthol to upward of 1,000 patients, without a single untoward result, excepting some unimportant symptoms of local irritation. In regard to these latter, he repeats with emphasis the warning contained in his former publication on the subject, viz., that *naphthol is a very active remedy, never to be employed without due caution*, and whose indications can only be learned by watching its effects in actual practice.

In this way it has been found that an oily solution of naphthol, in the proportion of fifteen to twenty per cent, or even of greater strength, produces no irritating effect whatever, or hardly any, upon the healthy skin, while a single application of a one-per-cent ointment may set up an acute inflammation in an irritated portion of the cuticle, or may change a scaly into a moist eczema. On the other hand, a very weak alcoholic solution has a powerful effect on the healthy skin, and of course acts like poison in cases of eczematous inflammation. The obvious conclusions are that, when using such a remedy as naphthol, we must begin with weak preparations applied to limited areas, and must never anoint the whole surface in the case of young persons, or where the cuticle is newly formed and tender, or has partially lost its epidermis. Neither should the strong alcoholic solution be indiscriminately employed.

It is in scabies that this remedy has achieved its most striking results. Our author regards it as especially suited to the hospital management of this complaint, because *a singleunction is sufficient for a cure*, without bathing or any other preparatory measure, and because the sound skin is but slightly irritated, and the patient's linen and bed-clothes hardly at all soiled by the process. Accordingly, having previously been employed with great success, all Prof. K.'s scabious cases since April, 1881, have been treated with naphthol in the following combination.

R. Axungiae (or ungu. emoll.)	100 parts.
Sapon. viridis.....	50 "
Naphthol.....	15 "
Cret. alb. pulv.	10 "

M.

This is rubbed briskly into the localities chiefly infested by the itch-mites, and the patient is then powdered with starch and wrapped in flannel blankets.

Unless the case is unusually complicated with eczema, he is discharged cured on the following day. In private practice he may put on his ordinary clothes over a woolen shirt and stockings, and go at once about his business.

Of the other cutaneous maladies mentioned in connection with this method, prurigo and ichthyosis stand forth prominently, although the variously complicated forms of eczema receive the longest notice. For *prurigo*, naphthol is recommended in the highest terms as a blessing alike to the patient and his attendants. The same simple treatment applies to all cases of the complaint, both in hospital and private practice. An ointment composed of five parts naphthol to 100 of ungu. simplex (or emolliens) is every evening rubbed sparingly into the parts affected by the eruption (generally the sides of the upper and lower extremities and the sacral region), which are also powdered over with the remedy. Not so much as a preliminary bath is ever given in addition, so that "the surprisingly rapid curative result" is solely attributable to the naphthol. Precisely the same course is followed in *ichthyosis*, though in difficult cases of the latter, the epidermis may require to be loosened by a long-continued use of *sapo viridis* or *ol. jecor. asell.*, 100; naphthol, 2. The results obtained were always highly favorable.

Both these diseases (*prurigo* and *ichthyosis*), we are told, require that persevering attention should be bestowed upon the skin, even after it has become perfectly normal in appearance. It will be sufficient, however, to wash with sulphur soap, and to apply the naphthol ointment every two or three days.

INOCULATION OF SYPHILIS BY SKIN-GRAFTING.

A man 49 years of age, was attacked in January, 1881, by gangrenous erysipelas, which, arising from a superficial ulcer on some hemorrhoids, involved the superior third of the left thigh, and entirely destroyed the integument, with the cellular tissue of the anterior surface of the limb. On March 7, skin-grafts, taken from five persons aged from twenty to forty years, were planted on the outer surface of the granulating ulcer, which measured not less than three square decimeters. Thirty-three of these grafts became adherent. March 18, twenty-eight grafts were transferred from the buccal mucous membrane of a rabbit. These disappeared by cellular absorption. March 23, forty grafts, taken from seven individuals from twelve to fifty-four years old, were inserted over the outer portion of the ulcerated tract. Of these, thirty performed their office. Owing to the success of these operations, the whole of the affected surface had already begun to heal, when, on the 5th of April, an excavated ulcer of a bluish-gray color, and as large as a quarter-dollar, appeared on the outer surface of the limb, where the first set of skin-grafts had been inserted. These were quickly succeeded by others, so that, in the course of three days, the commencing cicatrix was completely destroyed. Ten weeks after the performance of the first skin-grafting, namely, on the 19th of May, a very decided roseola made its appearance, which was soon followed by a crusty eruption on the scalp, and afterwards by mucous patches in the mouth. About this time, one of the patient's sons, a young man

aged twenty-five, who had furnished grafts from his own person on each of the above-mentioned occasions, called to consult M. Deubel on account of certain pains and a troublesome itching of the anus which he had lately experienced. He, too, was found to have mucous patches, and confessed to having had, eighteen months previously, a chancre, for which he had not thought it worth while to place himself under treatment. "It thus appears," says M. Deubel, "that I had inoculated my patient with syphilis by means of blood adhering to the skin-grafts taken from his own son." The original ulceration was not completely healed until a few weeks ago—i. e., eight months from the commencement of the erysipelas.—DEUBEL, *Gaz. Méd. de Paris*, Nov. 5, 1881.

SUBCUTANEOUS INJECTIONS OF IODOFORM IN SYPHILIS.

This communication (which the author states is to be regarded as preliminary to a more detailed consideration of the subject) contains a brief account of results obtained from the subcutaneous employment of iodoform in several cases not enumerated or particularly described.

The iodoform made use of was suspended in glycerin, in the proportion of 6.00 to 20.00. The dose in the beginning was 0.30 of iodoform—afterwards raised, as it was found to be well tolerated, to 0.75. At the same time, trials were made with an oily solution of iodoform, in the proportion of 0.30 of iodoform to 60 cc. of sweet almond oil. For the treatment, a selection was made of recent cases, but in which considerable hard swelling of the inguinal glands already existed. After ten to twelve injections at different places, a retrogression of the morbid phenomena could be observed. No abscesses were produced. A few of the patients complained of slight pain after the injections, which, however, was of short duration. Next day, the skin around the puncture was a little reddened and somewhat sensitive to pressure; and the spot was raised and rather harder than the surrounding integument. These symptoms disappeared gradually.

The effects upon the skin of the oily solution of iodoform were rather more decided. The seat of the punctures exhibited an erysipelatous redness, which lasted for forty-eight hours, though there was no hardness. This was owing to the fact that the iodine became separated when the solution had stood for some time—the latter assuming a brown color, after which its effects were more irritating.

Iodine could be detected in the urine in two hours after an injection. The characteristic iodine odor was not perceptible, either in the breath, the perspiration, or the urine.

The patient's general condition was unaffected.

It was probably owing to the smallness of the dose that no narcotic action was produced, such as Binz and Högyes observed in their experiments on animals.—THOMANN, *Cent. f. d. Med. Wiss.*, Oct. 29, 1881.

DIFFERENTIAL DIAGNOSIS BETWEEN LEPRA, LUPUS AND CANCER, AS THEY AFFECT THE THROAT.

1. Lepra is always apparent on the skin, before the throat gives any manifestation of its presence.

Either lupus or cancer may sometimes exist without giving rise to any cutaneous affection.

2. Lepra always announces its onset by a reddish discoloration, which gradually disappears and is succeeded by paleness without tumefaction.

Lupus is developed on the mucous membrane without any morbid alteration in the latter.

Cancer commences by congestion, swelling, and slight pain in the region affected.

3. The tubercles of lepra are white, soft, and of variable size. They form a chain resembling a string of beads. Their sensibility may be normal, diminished, or completely abolished.

The tubercles of lupus are pinkish or red, hard, resisting, and elastic. They are larger than those of lepra, few in number, scattered, and generally indolent.

The tubercles of cancer are red or grayish. They are either hard or soft, and are troublesome by reason of the pain they occasion.

4. There is well-marked tumefaction of the mucous membrane in lepra; in cancer, a hard oedematous swelling. The tubercles of lupus are seated on a structure which retains its normal condition.

5. The ulcers of lepra are soft, somewhat resembling syphilitic mucous patches; in some cases they are insensible.

In lupus the borders of the ulcers are hardened and elevated; their bases constricted, sinuous, and without odor.

The ulcers of cancer are large, with irregular bases, and are covered and surrounded by papillary growths. Usually, they are exceedingly painful.

6. The cicatrices of lepra and those of lupus are very similar in appearance and consistence. They differ in that the cicatrices of lepra are insensible, while those of lupus preserve a degree of sensibility corresponding to that of the surface which they occupy. In cancer there is no cicatrization—either complete, partial or temporary.—DR. DE LA SOTA Y LASTRA (*Rev. de Laryngol., d'Otolog., et de Rhinol.*, August, 1882).

VIOLA TRICOLOR IN CHRONIC ECZEMA.

J. FERGUSON reports a case of chronic eczema of the face, in which the skin was very thick, much infiltrated, and deeply fissured in many places, the patient suffering greatly from itching and burning. The disease was of long standing, and the skin dry and scaly. Other methods of treatment having failed, the patient was directed to use daily an infusion of *viola tricolor* made by steeping two drachms in ten ounces of water. All local treatment was suspended. In a week the skin began to discharge a large quantity of serum, and there was more inflammatory action than before. The drug was then discontinued and a mild saline diuretic ordered. In a few days the *viola tricolor* was resumed in smaller doses, about forty grains daily in infusion. This was continued six weeks, at the end of which time the patient's general health had much improved, and the appearance of the skin was very favorable, the patient sleeping well and enjoying a degree of comfort unknown for several years.—*Canadian Jour. of Med. Scien.*, April, 1882, and *Archives of Derm.*, October, 1882.

TREATMENT OF GONORRHEAL OPHTHALMIA.

MR. CHARLES BADER, surgeon to Guy's Hospital, strongly recommends the use of the following ointment:

℞ Red oxide of mercury.....one grain.
Daturine or atropine.....one-fifth grain.
Vaseline.....one ounce.

M.

The ointment is to be injected twice a day under the upper lid by means of a small glass syringe with a flat nozzle. The surrounding parts are to be thickly smeared with the ointment and the eyes bandaged. In three cases reported he obtained excellent results.—*Lancet*, October 14, 1882.

Correspondence.

LEPROSY AMONG THE NORTH AMERICAN INDIANS.

To the Editors of the JOURNAL OF CUTANEOUS AND VENEREAL DISEASES.

I have been investigating the matter of the existence (present and former) of leprosy in the Northwest, and particularly about my own region of country for past two years, and am in the habit of keeping notes of any fact gained in relation to the disease.

I treated a Mrs. H. with the disease in 1880; she died in 1881; she lived at Cathlamet, W. T. I am not sure that there are any other cases at that place now, but believe there are. A Mrs. A., I believe of the same place, died with the same disease some fifteen years ago. A sister of Mrs. H. (first named), I think, died with the disease some years ago, and I am told by the Indians that Mrs. H.'s grandmother, who was also an Indian woman, died with a similar disease to Mrs. H. I have very conclusive evidence that there has been for the past forty years more or less of leprosy among the Indians living between the Columbia River and Puget Sound. The Indians have died away (comparatively); not so much with leprosy, as with scrofula and small-pox. etc. I believe there is some leprosy among them yet. I do not know of any leprosy among the whites. There is a general impression that the Chinamen have leprosy on this coast. That may be so in California, but I have not seen one that I suspected to have leprosy in this country; and I may add that my opportunities for observing have not been limited, as several thousand Chinamen are employed here in the canning establishments. Yours,

AUG. C. KINNEY, M.D.

ASTORIA, OREGON, NOV. 20, 1882.

Received.

Della Trasmissione Accidentale della Sifilide; Studio pratico del Dottor CELSO PELLIZZARI. (Reprint.)

The Malignity of Syphilis. By DR. L. D. BULKLEY. (Reprint.)

Items.

NOVEL CUTANEOUS ANATOMY.—We are in receipt of a pamphlet recommending a new apparatus for vapor baths, etc., in which we find the following contribution to dermal anatomy and physiology: "The epidermis is formed of numerous small glands, generating the aqueous and sebaceous secretions which expel the carbonic acid and produce gradual perspiration."

NOTICE TO AMERICAN DERMATOLOGISTS.—The editors of the "*Monatshefte f. prak. Dermatologie*" are desirous of obtaining for review, copies of all American books, articles, or reprints on cutaneous subjects that have appeared during the past fifteen years, and authors are kindly requested to forward them to the care of Leopold Voss, Amelungstr. 4, Hamburg, Germany. We can assure authors that if the views expressed differ from those held by the reviewer, they may expect heroic treatment, and as an example we may cite a *Critique* by QUINCKE in the December number of the *Monatshefte*.

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VOL. I.

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No. 6.

Original Communications.

PSORIASIS AND OTHER DISEASES ASSOCIATED WITH VACCINATION.

BY

THOMAS F. WOOD, M.D.,

Wilmington, N. C.

ONE of the earliest charges against which the promulgators of vaccination had to defend the practice was that skin diseases were engrafted with the virus, and that the danger from this source in many instances outweighed the pretended benefit of protection. The stock pictures of Rowley, Moseley, and "that pert little Squirrel," as Jenner called the latter, anti-vaccinists of the most rabid sort, who flourished in the earlier days of vaccination,¹ were hideous caricatures of impossible skin diseases.

Very early, too, the best dermatologists were called upon to study phenomena all new to them, not only to satisfy themselves and their professional confrères, but to have wherewithal to combat the popular anti-vaccination clamor. Willan,² the most eminent dermatologist of his day, by the aid of his friend Bateman, collected the statistics of the Public Dispensary in London to show that the number of chronic skin diseases were in no larger proportion in the sixth and seventh years after the introduction of vaccination than before (1798).

All the way down through the century, at those periods when the

¹ *La Vaccine Combattue dans le Pays où elle a pris naissance*, etc. By Wm. Rowley, Moseley, and R. Squirrel. Paris, 1807.

² *On Vaccine Inoculation*. By R. Willan, M.D., F.A.S.

anti-vaccinists have been in active opposition, lay accounts of hideous skin diseases have been very diligently published, while the professional mind has for the most part been satisfied with devising arguments to combat these stories. But post-vaccinal eruptions have not received such careful investigation as their importance demanded. What we know of them lies scattered through the medical periodicals during fifty years.

At the last meeting of the American Dermatological Association, Dr. Rohé,¹ of Baltimore, reported cases of psoriasis following vaccination. This interested me greatly, because I had just been studying a case of psoriasis completely cured by a re-vaccination.

CASE I.—Charles B., aged twenty-one, consulted me for an inveterate psoriasis. He had been under treatment by several physicians, with no good results. I directed phosphorus internally, and goa powder externally. The goa powder caused so much erythema, especially around the patches on the face, that he gave up the treatment, and passed from my observation, as I learned afterwards, not improved. In March, 1882, it became necessary to vaccinate the operatives in a factory where my patient was engaged, and, although he had been previously well vaccinated, to set the example to the faltering negroes, he was again vaccinated with fresh bovine virus.

At the time of his vaccination, he had many patches of psoriasis. The vaccination ran a regular course, leaving a faintly outlined cicatrix. But singularly enough, with the termination of the vaccine disease, his psoriasis disappeared, and up to this time he has had no return.

CASE II.—About the same time, Mrs. G., a middle-aged lady, submitted to a primary vaccination with virus of the same stock. At the time of vaccination, she had an eczema of long standing. Particularly the eruption about the face was unsightly and annoying. There was some doubt at the time whether or not the operation should be performed, on account of the existence of the eczema. With the subsidence of the vaccine disease, the eczema disappeared, and until within a few weeks ago there has been no reappearance of it, except some slight redness and exfoliation of epidermis about the eye-brows.

CASES III. and IV.—Two girls, sisters of Case I., had had previously no sign of psoriasis. They are aged respectively eight and eleven years. In the spring of 1882, they were vaccinated with bovine virus of the same stock as that used in the other cases. With the subsidence of the vaccine disease, each one of these girls had an eruption of psoriasis, which has now lasted nearly a year.

These anomalies of vaccination are presented for further study, and as a contribution to the subject, and to set the practitioner to thinking, if it is best to withhold vaccination because of all pre-existing skin diseases. Jenner was prudent in warning the doctors in his day that a child with an eruptive disease was not in fit condition to be vaccinated.

¹ This JOURNAL, October, 1882.

There were two good reasons. First, all vaccinations were done with humanized virus, and accidents and abnormal vaccinations could easily be charged to the impure state of the blood of the vacciner. Secondly, a very early experience showed that vaccinations in patients affected with the exanthemata were likely to become abortive, and in persons having pre-existing eczema, or herpes, or other skin disease, would have a bad vaccination. By all these mishaps, the practice of vaccination was damaged, and the line of pure transmission jeopardized.

Standing at a new era in the science of dermatology, these opinions need to be revised. For if, as in the cases we have enumerated, vaccine disease can supplant such formidable diseases as psoriasis and eczema, even in a few cases, we may find in vaccination a remedial as well as a prophylactic agent. The strong objections would not obtain, as formerly, against the policy of this procedure, because we are now enabled to get prime cow-pox, and thereby prevent any break in the line of our humanized stock. This point of view is largely in the interest of the management of stubborn skin diseases, and leaves out of sight too much the paramount necessity of prophylaxis. It has the disadvantage of being available only once in a life-time, or, if more than once, after a long interval.

One more observation in connection with this subject. I am satisfied that no virus less active than prime cow-pox (bovine virus) would induce constitutional symptoms severe enough to supplant psoriasis. In fact, the observations on skin diseases associated with vaccination, finding their way into the journals so abundantly just now, carry us back to the first decade of vaccination when cow-pox virus of an early remove, corresponding very nearly to the bovine virus now current, was in use.

PSORIASIS FOLLOWING SCARLET FEVER.

BY

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CASE I.—Minnie C., æt. 11, applied for relief, suffering with an extensive psoriasis. The patient's mother said that her daughter had just recovered from scarlet fever, and that, while the scarlatinal rash was fading, she noticed several small reddish spots on the chest, and that the eruption had rapidly extended to other portions of the body. Upon examination, the arms and legs were found thickly covered with the eruption, which was also largely diffused over the trunk, and a few small patches on the scalp. Neither father nor mother

had suffered from skin disease at any time. Patient recovered under appropriate local treatment.

CASE II.—John A., æt. 9, soon after an attack of scarlet fever, presented himself for treatment for a well-marked psoriasis. The patches had made their appearance first on the chest, and subsequently rapidly invaded other regions. Upon examination, the arms and legs were found particularly rich with the eruption, several patches being also present on the back, scalp, eye-brows, and face. Patient disappeared from observation before any decided treatment could be instituted. No history of skin disease in the family.

CASE III.—Suzie G., æt. 12, was taken sick with scarlet fever. The disease was of medium intensity, and followed a typical course. As the rash commenced to fade, I noticed several small reddish elevations on the right thigh, over the course of the femoral vessels, extending from just below Poupart's ligament to within two inches of the apex of Scarpa's triangle: they soon developed into well-formed, typical psoriasis, which immediately invaded different portions of the body almost simultaneously. Patches were present on the scalp and eye-brows; the face even was not spared. It was a difficult matter to find the smallest portion of sound skin on the lower limbs. The eruption was less profuse on the arms, and scattered around the circumference of the trunk. The hands and feet offered no lesion. Parents had never suffered with any skin disease.

The interesting facts to be observed in the above cases, which are undoubted, typical psoriasis, are: That they all supervened during scarlet fever; the extreme rapidity with which the eruption spread; the extent of surface invaded; the regions invaded; the situations where it first appeared, viz., chest and thigh—whereas in ordinary psoriasis the elbows and knees are generally attacked first, the back coming next in frequency for the incipient appearance of the disease; the involvement of the face, which is rare; the age of the patients, psoriasis rarely showing itself before early adult life. It will also be noticed that the psoriatic patches appeared first on those regions of the skin first invaded by the scarlatinal rash, and where, perhaps, it attains its maximum intensity.

In scarlet fever, there is a tendency to hyperæmia and proliferation of the cells of the rete mucosum, with serous effusion and migration of leucocytes between them, giving rise to desquamation. In psoriasis, we also find hyperæmia and hyperplasia of the stratum mucosum, effusion of serum, and migration of the white blood-cells, and consequent exfoliation.

In view of the above facts, it seems possible that the exanthem first produced a perversion of cell-life in the rete Malpighii, and that the psoriasis was only an intensification, in skins predisposed to it, of a pathological condition produced by the eruptive fever.

The exanthem, then, was the exciting cause, without which the

psoriasis might not have been developed until the usual period for its appearance, or, perhaps, have been omitted altogether, provided no disturbance of the normal cell-life be produced by some other exciting agent. For report of similar cases by Dr. Taylor, see p. 14, No. 1, JOURN. CUT. AND VEN. DISEASES.

GENERAL VESICULO-PUSTULAR ERUPTION FOLLOWING VACCINATION.

BY

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E. K. S., male, blonde, large, well-nourished, of healthy parents, born October 23, 1880, developed eczema on cheeks and about head when two months old, and this gradually increased until, February 1, it covered cheeks, forehead, chin, upper portion of chest and arm, and a narrow ring about neck. There were also three small patches on abdomen, and one of moderate size on each leg below knee, head somewhat improved. February 2 was vaccinated with one of Martin's ivory points. His mother was re-vaccinated effectively at same time. On the 9th a white ring encircled point of vaccination. 11th: This had become vesiculated, and was surrounded by a row of vesicles closely connected. 12th: Vesicles of similar character on arm, shoulders and chest, and a few on neck. 13th: Developed on cheek, and developing on forehead and chin, also on submaxillary and subauricular glands, which were swollen. 14th: Developed on head about the eyes and mouth, with a few on nose. The earlier vesicles had become pustules, and in some of them umbilication was marked. 16th: In the early morning seemed oppressed and sinking. At about half-past one P.M., difficulty was pronounced variola, confluent type. At this time the cheeks, forehead, and chin were covered with pustules, most of which had coalesced. They were also very abundant on upper arms and shoulders, across chest and about the neck, and many of them were aggregated. There were scattering ones on the head, the arms below the elbows, and many of these were distinctly umbilicated. General color yellow. About this time a few pustules developed on the nose, the back of the hands, the three small patches on abdomen, and two on the left leg. There were no other on the legs, and none on the back below the neck, unless possibly one near the end of the spine. On the 18th, some of the pustules were maturing, and most of them were advanced. A slight crust, with a greenish tinge, was on the cheeks, and in a lesser degree on forehead and chin. Each cheek was fully covered by pustules entirely coalesced, and the same was true of the forehead and chin. At 9 P.M. a convulsion occurred, lasting more than an hour. On the 21st, a severe attack of colic was followed by convulsive action. Pustules matured as they

appeared ; those on the cheeks were discharged, while those on the forehead and chin were still intact. Some small ones about the nose and on the eyelids were last to mature. As improvement continued, cicatrices seemed in some cases raised and in some decidedly depressed, but all were much affected by eczema.

There was also an ulcer on right eye, and cicatrices were apparent in the throat, especially on tonsils.

Until the disease was pronounced variola, Dr. Lloyd and myself regarded it as a hybrid—the result of vaccination upon a system already burdened with eczema ; or, according to Fox, vaccinola coupled with eczema. After that our views were necessarily held in abeyance.

We now believe that our diagnosis was correct, and that the mother's vaccination increased the little patient's constitutional difficulty, and added to the severity of the disease.

ON THE INCIDENTAL EFFECTS OF VACCINATION.

BY

P. A. MORROW, M.D.

THE introduction of the virus of cow-pox into the human system develops a lesion at the point of inoculation which pursues a typical course in its development and decline, and is usually attended with slight constitutional disturbance. Ordinarily the morbid appearances occur at definite periods and with the same regularity as do the symptoms of other specific contagious diseases, as scarlatina, measles, etc. In some cases, however, the evolution of vaccinia does not take place in this regular and definite order, but certain irregular and anomalous effects are observed.

These may consist in deviations from the typical course of the vaccine pustule, or they may relate to anomalies in its constitutional effects, and the occurrence of general eruptions with or without febrile reaction. The local vaccinal irregularities may consist simply of an abortive or arrested development of the pustule, or of certain inflammatory changes which, commencing in the vaccination lesion as a starting-point, may result in a purulent ulcer, a sloughing sore, or an erysipelatous inflammation, involving a greater or less extent of surface.

The general eruptions may vary from a slight roseola to a papular, vesicular, or pustular eruption, occurring in connection with a perfectly regular development of the vaccine pustule, or they may refer to constitutional effects which are doubtless due to the introduction of a septic

poison or the virus of some other specific disease in the process of vaccination.

The clinical appearances and pathological significance of vaccinal eruptions have not been sufficiently studied, and their relations to vaccine matter and to skin diseases in general have not been definitely determined. I have preferred to characterize these anomalies as *incidental effects*, for while they are undoubtedly caused by the process of vaccination, they may be regarded as the indirect and occasional, rather than the direct and constant, results of that process. They have certain analogies with the phenomena of abnormal drug action, or what has been termed the "incidental effects of drugs," which may take the place of normal action, or appear simultaneously with it.

A knowledge of the nature and significance of the incidental effects of vaccination is of the greatest interest and importance to the physician, not only in enabling him to appreciate their relation to normal vaccinæ, and thus estimate the measure of their protective value, but they derive a certain practical importance from the fact that the occurrence of an eruption after vaccination almost always excites a suspicion that "bad matter" has been used. However groundless such a suspicion may be, the physician should be familiar with and able to interpret the unexpected phenomena, as well as the normal action, of every agency which he employs, either for the prophylaxis or cure of disease.

First in point of development, if not in importance, are the irregularities observed at the place of vaccination or in its immediate neighborhood. The series of changes which characterize the different stages of a normal vaccination are too familiar to be here noted. There may be an acceleration or a retardation of these different stages within the limits of a successful vaccination. Deviation from the typical course may depend upon the character of the lymph used, although Mr. Seaton, the highest English authority upon vaccination, says that "neither in the size of the vesicle nor in the severity of its local symptoms, nor in the length of the period which the eruption takes to run its course, is there any notable difference between animal and humanized lymph." The experience of the profession in this country with bovine lymph shows that it is slower in its development, more intensely irritant in its local and constitutional effects, and more prolonged in its active continuance. Thus papulation may be deferred until the tenth or twelfth day, the areola may not be complete until the fourteenth or sixteenth day, and desiccation is not infrequently prolonged until the fourth or fifth week.

It is well known that the development of the pustule is influenced by the existence of other diseases, especially cutaneous disorders, such as eczema, vesicular eruptions, etc., and also by the pathological change effected in the tissues by a previous vaccination. There are many other peculi-

arities in the evolution of the vaccinal pustule noted by the earlier vaccinists and confirmed by later experience. Thus the period of incubation may be prolonged until the twentieth or thirtieth day, more exceptionally until the second, third, or fourth month, in one case reported by Rayer until the sixth month, or even longer, when the dormant virus will arise from its repose and manifest its specific effect by the development of a perfectly characteristic pustule. Again, there have been recorded instances where an inoculation has proved to all appearances absolutely negative, while a second inoculation, practised several weeks, months, or even years later, not only develops pustules at the points of second inoculation, but also at the points where the virus was first inserted. Still again, it has been observed that when multiple insertions of the virus have been made at the same time, pustules will develop at a number of the points and run a regular course; when this is finished, the remainder of the insertions, which had, apparently, proved ineffective, now develop pustules which in their turn go through the same process. The literature of vaccination abounds in observations of this nature illustrating the vagaries of action of the vaccine virus. It will be observed that they relate to the period of incubation rather than the character of the pustule. It is generally held that when vaccination produces a typical, umbilicated vesicle with a well-marked areola, its retarded development does not vitiate its protective value.

Under the head of spurious or false vaccinia have been classed certain departures from the normal type. They chiefly relate to deviations in the anatomical form of the vaccine vesicle, the distinctive, specific character of which is depression of the centre or umbilication. In contradistinction, the spurious vesicle or papulo-vesicle is acuminate or conoidal in shape, and is further characterized by precocity of development, shortness of duration, and pigmentation, or imperfectly-marked cicatrix. A number of varieties have been described.

1. A vesicle containing opaque or straw-colored lymph, which makes its appearance usually on the second day; it is irregular in form, and the areola may be complete by the fourth, fifth, or sixth day. There is nothing fixed or definite in its course; it suppurates, dries up, the scab usually falls off by the tenth day, leaving a pigmented base.

2. A small, reddish tubercle, more sensible to the eye than the touch, enlarges to fourth or fifth day, crusts over, dries up, and disappears, leaving no cicatrix.

3. A single bulla, or, instead, a group of herpetic vesicles, containing transparent fluid, developed from a non-infiltrated base, with thin, tense walls, which soon burst. The exuded fluid may give rise to eczematous or phlyctenular eruptions.

4. A vesicle which may run a normal course until the eighth or ninth

day, then rupture, crust over, with progressive ulceration beneath. This ulceration may extend both superficially and deep. There is usually pain and swelling of the axillary glands, and a high degree of constitutional disturbance.

5. Finally may be mentioned a pigmented tubercle which, from its erratic course and the eccentricity of its orbit, would seem to be a new-comer in our vaccinal system. It is supposed to be a specific product of the bovine lymph, as its appearance dates from the introduction and general use of animal vaccination in this country: it is known as the "raspberry sore." I have twice had an opportunity of studying this pigmentary neoplasm *in propria persona*, as well as in numerous patients vaccinated by me.

It is usually formed by the coalescence of a number of small papules, the appearance of which, twelve to fourteen days after vaccination, is preceded by intense itching, or it may develop from a single papule. The tubercle so formed increases in size until it attains the dimensions of a large pea or coffee-grain. It is usually globular or irregular in form, and of an apple-jelly hue, varying from a bright to a dusky red. It is soft and elastic, and gives a deceptive indication of fluid; its puncture is followed by the escape of a drop of reddish serum, the inoculation of which, according to some observers, produces a lesion of identical character. After full development it is indolent, showing little tendency to undergo progressive change. In the course of from four to eight weeks it gradually disappears, leaving a pigmentation but no cicatrix. It is very itchy during its entire evolution, and after its disappearance leaves in its train a pruriginous condition of the skin, which may persist for several months, or even longer. I was asked the other day to examine the arm of a physician who had developed a "raspberry sore" in vaccinating himself four years ago. It was very slow in its involution, and itching of an extremely annoying character has been intermittingly present ever since. Upon examination I found only a roughened, papular condition of the skin in and around the place of vaccination. So far as I am aware, no microscopical examination has been made with the view of determining the histological characters of the raspberry tumor. Dr. Taylor, of the New York Board of Health, refers to it as a "fungous vesicle," "cellular in structure," and "caused by the use of bovine lymph, which is beginning to deteriorate," and thinks that it possesses little or no prophylactic power.

My friend, Dr. Foster, informs me that he has seen this red tubercle develop upon the calf, though exceptionally. It is ordinarily encountered as a revaccination phenomenon, but numerous instances have been reported of its occurrence in primary vaccination.

As intimated above, the prevalent impression is, that this raspberry

tubercle is a new phenomenon, peculiar to animal vaccination. This assumption seems to me hardly legitimate. It has certain points of resemblance with the red tubercle described by Bosquet occurring after the use of humanized lymph. Its late development and longer persistence may be due to a peculiar quality of the bovine lymph, which should be no less strikingly manifest in spurious than in true vaccinia.

These aberrations from the regular course of the typical vaccine pustule derive their chief interest from the relation which they bear to true vaccinia. Indeed, the propriety of classing them as spurious vaccinia is open to question; they owe their origin to the same source as true vaccinia: they are accompanied by the same local and constitutional phenomena—pruritus, local inflammation, pain and swelling of the axillary glands, febrile disturbance, malaise, etc. From a practical stand-point, the question is, Are they protective?

The determination of the prophylactic power of irregular vaccinia embraces considerations of the highest importance. The large and constantly increasing proportion of cases of post-vaccinal small-pox is, it is claimed, due to imperfect or ineffectual vaccination. This proportion, as stated by Mr. J. F. Marson in his classic article on "Small-pox," in "Reynolds' System of Medicine," was at that time (1863) 84 per cent. In the twenty years which have elapsed since then, the ratio has increased to 95 per cent. The records of the London Small-pox Hospital for six months ending June, 1881, as quoted by Mr. Drysdale (*Med. Press and Circular*, August 9, 1882), show that of 491 cases of small-pox admitted, 469 had been vaccinated and only 22 had not been vaccinated; so that an imperfect vaccination may afford not protection, but simply a false sense of security. The consensus of medical opinion upon this point may be formulated as follows: Occurring as a result of primary vaccination, an "abortive" or "irregular" pustule is regarded as worthless, and accepted as an indication for an immediate repetition of the operation. But, occurring as a revaccination phenomenon, this opinion is not so pronounced. It is generally regarded as an evidence of the continuance of the protective influence conferred by an anterior vaccination, which has so modified the system as to render it less apt to receive and develop the vaccine virus in a normal manner. On the other hand, the development of a typical pustule running a regular course is regarded as an evidence that susceptibility to small-pox, extinguished by previous vaccination, had arisen from its ashes and was again in active existence. In other words, susceptibility to vaccination indicates susceptibility to small-pox. The incorrectness of this proposition appears from the fact that persons who have had small-pox may be successfully vaccinated. The statistics¹ furnished upon

¹ Reynolds' System of Medicine, vol. 1, p. 176.

this point by Mr. Seaton are conclusive. Of 1,000 soldiers in the British army who bore marks of previous small-pox, vaccination gave a perfect result in 451; of 1,000 who bore good marks of previous vaccination, the result was perfect in 484; of 1,000 who bore no marks of previous vaccination or small-pox, only 326 were successfully vaccinated, which, if vaccination were a reliable test, would prove that persons who have had small-pox are more liable to it than those who have never been vaccinated, which is, as Mr. Seaton has clearly pointed out, “a *reductio ad absurdum*.”

The practical question which presents itself is this: Does the development of an “irregular” pustule in revaccination indicate liability to small-pox, and consequently the reperformance of the operation? It must be confessed that the teaching of science upon this point is by no means fixed and definite. The experience of more than three-quarters of a century has failed to furnish an absolute test by which we can determine whether an individual “has undergone that inexplicable change which secures him against small-pox.” The phenomena of revaccination, whether it be a negative, an irregular, or a perfect local result, do not afford a criterion as to the patient’s liability to small-pox. This fact is not an argument against vaccination, but an illustration of the truth, corroborated by daily experience, that there are many problems connected with the prophylaxis of small-pox which still remain unsolved.

Ever since the introduction of the practice of vaccination there have been occasionally observed, in addition to the series of local changes which take place at the point of inoculation, general eruptions affecting a greater or less surface of the body. While the occurrence of these vaccinal eruptions has been signalized by numerous writers, little attempt has been made to group and classify them according to their clinical characters, and determine definitely the precise external and internal ætiological factors concerned in their production. The comparative frequency of these eruptions was recognized by the earlier vaccinists. Willan, who wrote in 1806, estimated that a profuse miliary eruption occurred in one out of every fifty persons vaccinated. Referring to these eruptions he says: “These circumstances we should judge by analogy desirable, but they do not always occur, nor are they deemed requisite to secure the full effect of vaccine inoculation.”

Vaccinal eruptions may be grouped according to their elementary lesions as follows:

Erythematous Eruptions. — This variety, known as *Roseola Vaccinia*, usually first shows itself in the vicinity of the vaccinated point, and thence spreads over a large extent of surface. In some cases it appears as a diffuse bright-red efflorescence, and may simulate scarlatina. In other cases it occurs as a patchy eruption of a dusky-red color, resembling measles. Not infrequently it commences as a macular or

mottled eruption, which, later, presents the aspect of a uniform diffuse redness, involving the whole surface of the body. In its appearance and mode of development it is suggestive of Rötheln or German measles. It would seem to be the form most frequently observed in this country, quite a large number of cases having been reported by Drs. Holt, Bowditch, Prince and others in the *Boston Med. and Surg. Journal*, 1882. Dr. A. J. Lawbaugh¹ reports sixty-eight cases of this form of eruption occurring in eight hundred cases of primary vaccination. In many cases numerous small vesicles were scattered over the patches which did not become pustular, but dried up in a few days. This eruption usually develops from the eighth to the tenth day, rarely remains vivid for more than forty-eight hours, and disappears in the course of a few days, leaving brownish stains. This pigmentation may remain evident for some time afterwards, occasionally there is slight desquamation. Preceding and accompanying the eruption, there may be slight febrile reaction, headache, malaise, and other evidences of constitutional disturbance.

Urticarial Eruptions.—An urticarial eruption sometimes occurs the day after vaccination, or later. It may affect not only the skin but the mucous surfaces. The distinguished Prof. Hardy reported at the meeting of the International Medical Congress, London, 1881, that he came near losing his life from an urticaria supervening upon vaccination, which involved not only the skin but the bronchial mucous membrane, threatening suffocation. Like urticaria from other causes, it is extremely fugacious, and occasions no symptoms, except the subjective sensations of burning and itching.

Exudative Erythematous Eruptions.—An eruption, papular or tubercular in character, and closely allied in nature to erythema multiforme, is frequently observed. Like this eruption, it manifests a predilection for the extremities, more especially the hands and wrists, though it is by no means confined to these regions. These lesions are exceptionally large, in cases reported by Hardaway and others, “as large as the end of the thumb.” “I have been particularly struck,” says Hardaway,² “with the prevalence of erythema multiforme during the past winter, which was undoubtedly consequent upon vaccination.” This eruption may appear as early as the second day, but more usually on the ninth day after vaccination. The lesions undergo the characteristic changes in form and color, and are generally slow in their evolution.

Vesicular and Pustular Eruptions.—I do not include under this heading certain supernumerary vesicles sometimes observed within and immediately around the circle of the areola, which are, no doubt, the accidental products of the high degree of inflammatory action present,

¹ Boston Med. and Surg. Journal, April 20, 1882.

² Essentials of Vaccination, 1882.

but vesicles developed on surfaces more or less remote from the point of vaccination. From the relations of vaccinia and variola, one would suppose that a vesicular eruption would be the most common, as it certainly is the most characteristic form of vaccinal eruption. It occurs with comparative frequency, and may develop simultaneously with the vaccine vesicle and run a parallel course, or it may come out in successive crops. The vesicles are usually small, and present the character of a herpes, or a grouped eczema, and may be confined to a restricted locality, or may be more or less general. It is usually transitory, the contents of the vesicles becoming turbid, and drying up in the course of a week or so, rarely persisting after the fall of the scab. The vesicles are not umbilicated, and do not contain the vaccine virus.

There is, however, another form of vesicular or pustular eruption developed by vaccination, the lesions of which are identical in character with the typical pustule, and contain an inoculable fluid. The occurrence of a general pustular eruption has suggested the possibility of a generalized vaccinia, analogous to the eruption of variola. Whether the vaccine virus is capable of impressing a general action upon the whole system, in the same manner as the variolous poison, is still a moot question. Prof. Hardy and many other French authorities assert that a *vaccinée généralisée* is common. Dr. Martin, of Boston, reports a case¹ of generalized vaccinia in which at least four hundred "clearly defined, perfectly circular, invariably umbilicated vesicles were apparent." The contents of the vesicles were successfully inoculated. He also refers to two other cases which had come under his observation, in children suffering from eczema. Numerous examples of generalized vaccinia have been recorded by experienced vaccinators. French vaccination literature, especially, abounds in cases of this character.

The large proportion of these cases, however, are not due to the pathogenetic influence of the vaccine virus acting from within, but are, no doubt, instances of the phenomena of auto-inoculation. They are caused directly by the transference of the vaccine virus to an excoriated surface. They occur in persons who, at the time of vaccination, are suffering from some cutaneous disorder, generally eczema. The vesicle is broken by the patient's scratching, and the virus is carried by the nails to an abraded surface, developing lesions identical in character with the original. It would seem that a denuded surface was an indispensable condition of the inoculation, but Mr. Ceeley, whose opinion must always be quoted with respect, says "that a visible abrasion of the skin is not absolutely necessary."

This auto-inoculation may be affected, *at the time of vaccination*, by transference of the matter deposited on the vaccinated surface, in

¹Medical Record, April 15, 1882.

which case the supernumerary vesicles will appear on the fourth or fifth day, simultaneously with the vaccine vesicle, or, as is most frequently the case, the inoculation takes place from rupture of the vaccine vesicle on the seventh or eighth day, and the additional pustules appear, after the usual incubation, on the eleventh or twelfth day. They may come out in successive crops from successive inoculations.

The period during which auto-inoculation is possible is a matter of considerable practical interest. Bosquet thought that receptivity was extinguished after the sixth day. Trousseau indicated the ninth day as the limit, but numerous observations, which seem to rest upon unimpeachable testimony, extend this limit much further. Bonneric (Thèse de Paris, 1880) refers to cases where it was prolonged to the seventeenth day after vaccination.

Bullous Eruptions.—The development of isolated bullæ, pemphigoid in character, with thin walls which rupture readily, their exuded contents forming a thin, brownish scab, have been noted in connection with vaccination. Sometimes their contents undergo a turbid, opaque transformation, and dry up, without rupture. They rarely become confluent. They may appear the second day after vaccination, but they more frequently develop about the eighth or ninth day, sometimes not until the fall of the scab.

In this connection, I may mention a post-vaccinal bullous eruption which came under my observation, over three years ago :

Thomas Hynes, æt. eleven years, was brought to my class, at the New York Dispensary, on January 12, 1880. He had ichthyosis generally developed, only the head and face, flexor surfaces, palms and soles being free. He had been vaccinated with bovine lymph, three weeks previously. A large, deep sloughing sore occupied the point of inoculation. There was considerable œdema and an erysipelatous inflammation, extending from the shoulder to the elbow. Upon his face and forehead, there were a number of bullæ, from the size of a ten-cent piece to that of a half-dollar, in different stages of development. The bullæ had commenced to appear a few days before, some had partially dried up, and were covered with a shrivelled epidermis; the contents of others had become turbid and purulent. In the more recent ones the fluid was a clear serum. The bullæ were developed from a non-infiltrated base, and not surrounded with an areola. A number were seen in the supra-clavicular space, upon the penis, and around the pubes and inner portion of the thighs. I counted more than a dozen red papules upon the palm of each hand, which, on account of the thickened epidermis, had not yet developed into the vesicular stage. The localization of this eruption was, no doubt, determined by the ichthyosis. There was constitutional disturbance present. The patient passed from my observation for several weeks. I learned that the bullæ came out in successive crops, for two or three weeks later, some of them becoming confluent, and forming large sloughing sores. Three or four months afterwards, I again saw

him. Numerous cicatrices were observed, and two of the sores on inner side of each thigh had not yet healed.

The eruption, in the case just described, presents many points of resemblance to a varicelliform eruption, observed by Hebra, Hutchinson, and others, as not infrequent after vaccination. Hutchinson reports twelve cases of this varicella-like eruption, one of which proved fatal, which seemed to be more or less closely connected with vaccination. Most cases were diagnosed as chicken-pox, others modified small-pox.¹ "The eruption comes out copiously, and consists of clear, watery vesicles. . . . Their peculiarity consists in that the eruption, instead of disappearing, is indefinitely prolonged by the succession of fresh crops, and that the spots ulcerate and scab, sometimes becoming large sores." This eruption is very pruriginous, avoids the flexures, and is prone to affect the palms and soles. It may come out immediately after vaccination, or not until two to four weeks afterwards. It is of long persistence, and may last for several months, or even years.

Petechial Eruptions.—A purpuric eruption has been observed by Ceeley, Gregory, and others. In Dr. Gregory's case, the petechiæ appeared upon the skin, four days after the vaccination of a child apparently in perfect health. The areola was occupied on the eighth day by an extensive ecchymosis, and the body was covered with petechial spots, which had commenced to fade on the sixteenth day. Dr. Gregory regarded this case as one of petechial cow-pox, in which the influence of the vaccine virus, in the production of a hemorrhagic state of the system, was demonstrated. This eruption is rare. Dr. Gregory had never heard of but two cases of a similar kind.

Gangrenous Eruptions.—Under the designation of vaccinia gangrenosa,² Dr. Hutchinson has described a gangrenous eruption, occurring in a healthy child, after vaccination. The vaccine vesicle developed normally. On the eighth day, there was an eruption on the child's body, resembling variola. Three days later, the vesicles of the eruption were each surrounded by a large, red areola which developed with gangrenous patches. The child died in three weeks after vaccination. In a case reported by Stokes, purple-black spots appeared, within forty-eight hours after vaccination, which subsequently became gangrenous. The patient recovered. Prof. Hardy also reports a case of gangrenous eruption from vaccination, which terminated fatally.

Diathetic Eruptions.—The fact that vaccination may develop an eczema or other cutaneous disorder in persons predisposed thereto, was recognized by the earlier vaccinists. The existence of eczema, intertrigo, and other cutaneous eruptions was regarded by Jenner, Willan, and

¹ Rare Forms of Skin Disease (Hutchinson), p. 15 et seq.

² British Medical Journal, 1879, p. 960.

others as a contra-indication to the employment of vaccination. Since then, numerous writers have described an eczematous eruption, of a peculiarly obstinate character, which may be lighted up in persons who have never exhibited any manifestations of this diathesis. Dr. George Thin, in a paper on vaccinal skin eruptions (in *Ed. Med. Journal*, Dec., 1881), refers to cases of "obstinate eczema and other ailments" produced by vaccination. Dr. Rohé reports (October No. of this JOURNAL) two cases of psoriasis following vaccination, in persons who had never before been subject to this disease. In the same number, reference is made to a similar case, reported by Dr. J. Nevins Hyde, and also one by Dr. A. R. Robinson. Dr. Piffard gives notes of another case, in the January No. of this JOURNAL. In all these cases, the vaccinated spot became intensely itchy, infiltrated, and covered with white scales; later, a general eruption of psoriatic spots became disseminated over the body.

From this survey of the general eruptions incident to vaccination, we perceive that a large proportion of these anomalies occur in connection with a perfectly normal development of the vaccine pustule; that they are benign in character, transient in duration, spontaneous in their involution, and exert no appreciable influence upon the patient's health, with certain exceptions to be hereafter noted. They possess a certain practical importance from the fact that there is a general impression among the laity that they are caused by what is popularly termed "bad matter." This interpretation has furnished the most convincing argument by which the anti-vaccination prejudice has been fostered and kept alive, and has served as the basis of the most effective opposition to the general adoption of Jenner's discovery. However groundless such an assumption may be, it must be confessed that the profession has manifested a most decided unwillingness to recognize their direct dependence upon vaccination; but, as Dr. Thin has pointed out, "the legitimate influence of the medical attendant can only be strengthened and preserved by his being able to admit and explain their existence." Rightly interpreted, they furnish no more valid argument against vaccination than the occurrence of erythematous, urticarial, purpuric, and other eruptions, which sometimes follow the use of quinine, is a contra-indication to its employment as a therapeutic agent.

As regards their frequency, only an approximative estimate can be given. Experienced vaccinators have placed the proportion as not less than one in every fifty cases of vaccination. Behrend states that he observed them only six times in three hundred successive cases. To this number he adds a few others of which he received information from the mothers' statements. From the unusually large number of cases reported in the various medical journals within the last few years, I should judge that the proportion was much greater. Their more frequent occurrence

of late years in this country may be due to the greater potency or virulence of the "bovine lymph," which has been almost universally employed; for, as Mr. Ceeley has pointed out, "the local and constitutional effects of vaccinia are the more severe and the occurrence of general eruptions the more frequent the nearer we approach the animal virus."

They are more common in young children, especially in blonds, who have a fine, tender and succulent skin. As is well known, the skin of such children is more sensitive and prone to disorders of the circulation. They occur most often in spring and summer, which may be explained by the hyperæmia habitually present under a high temperature, and the abundant perspiration which favors the spontaneous development of cutaneous eruptions. Trousseau identifies certain vaccinal eruptions as *exanthèmes sudoraux*. Again their greater frequency in certain seasons may be caused by that intangible and mysterious "epidemic influence," the existence of which intensifies and exaggerates the effects of any noxious agency.

As regards the time of their development, it may be within forty-eight hours after vaccination; or, as is most frequently the case, not until the ninth or tenth day, corresponding with the maturation of the pustule. This period will vary within slight limits, according as bovine or humanized lymph is employed.

The distinguishing characteristic of the vaccine exanthem is the multiplicity and variety of forms which it assumes. It may be an erythematous rash, an urticarial exudation, a papular, vesiculo-pustular or petechial eruption. As intimated before, it presents many analogies with the incidental effects of drugs. In an article on "Drug Exanthemata," in the *New York Medical Journal*, March, 1880, I called attention to some of the more characteristic features of drug eruptions. An analysis of sixty cases of quinine eruption showed that this might be "erythematous," "erysipelatoous," "purpuric," "bullous," or "gangrenous," and that these dermatopathic effects were accompanied with what are regarded as the ordinary physiological effects of the drug. I attributed these eruptions to general vascular disturbance—the different lesions, macules, papules, wheals, vesicles, etc., representing different grades of the inflammatory process; in other words, the "drug exerts a direct irritant effect through the blood upon the tissues of the skin, causing disorders of capillary circulation, of which the eruption is but the outgrowth."

As regards the pathogenesis of vaccinal eruptions, it may be said that, with the exception perhaps of generalized vaccinia, and the pustular eruptions caused by auto-inoculation, they are not due to the specific

action of the vaccine virus. Although the participation of the organism as a whole is evident in the production of these general phenomena, yet we know that the essential character of a disease depending upon a specific *contagium* is shown in the development of specific pathological phenomena, which, though not absolutely invariable, yet exhibit a definite type. The specific product of the vaccine virus is an umbilicated vesicle, and we perceive even in the "abortive or irregular" pustule an attempt, feeble and impotent though it be, to conform to this type. In marked contrast appear the incidental eruptions we have been considering: they have in them nothing constant and definite, neither the period of their development, their course or duration; their very multiformity constitutes a fatal objection to the theory of their specific character.

In discussing the genesis of vaccinal eruptions, a number of factors are to be taken into consideration. It is well known that the irritation of the skin by the act of vaccination may cause a reflex vascular disturbance. The sympathetic lines which unite the various organs of the body, especially those of the same apparatus, are plainly seen in the production of urticarial and erythematous eruptions from the slightest irritation of the sensory nerves. These vaso-motor disturbances of reflex character are insufficient, however, to explain many of the phenomena under consideration.

The principal pathogenetic factor in the causation of vaccinal skin diseases is no doubt the presence in the blood of a morbid material, which may be the vaccine virus, or it may be the resorbed contents of the vaccine pustule. There is every reason to believe that from the moment of inoculation absorption of the vaccine virus takes place. Its circulation in the blood may produce an irritation of the tissues, revealed by an eruption within forty-eight hours after inoculation, or it may be powerless to produce an explosion of eruptive accidents until the accession of the febrile movement, symptomatic of the inflammation developed around the vaccine pustule. This febrile reaction, which has its analogue in the fever of the maturation of the variolous pustule, may be due, as has been suggested, to the resorption of purulent material. It is ordinarily at its height on the tenth day, a period which corresponds to the usual development of the vaccine exanthem.

In a paper on "Vaccinal Eruptions" Behrend states that there are two entirely distinct periods in which the eruptions occur, the first of which begins not later than the second day, and the second on the eighth day after vaccination. It may be well to bear in mind that his observations relate to the action of humanized lymph; with bovine lymph the stages are usually slower.

In considering the causation of vaccinal eruptions, one important

¹ Trans. International Medical Congress, London, 1881.

factor should not be ignored. Since they occur in but a limited number of cases, and in connection with a perfectly normal evolution of vaccinia, they must be regarded as epiphenomena, the essential condition for the production of which is individual predisposition. This may be a pathological predisposition, constituted by the existence of a cutaneous disorder, or a tendency thereto, as in the diathetic eruptions, or it may be a physiological predisposition, which is conveniently referred to as idiosyncrasy. I am aware that an appeal to this "mystery of individuality," in discussing pathological phenomena, is an attempt to explain *ignotum per ignotius*. We only know that in certain cases individual predisposition exists, and that its influence is imperious as it is inexplicable.

To summarize: The erythematous, morbilliform, scarlatiniform, and miliary eruptions occurring in connection with vaccination are the expression of the irritating effect of the vaccine virus, or its necrotic product, circulating in the blood, heightened and intensified no doubt by individual susceptibility; the extent of the eruption and its macular, papular or vesicular character representing different grades of inflammatory action.

The vaccine inoculation may be regarded as the occasion, rather than the cause, of the eczematous, psoriatic and pruriginous conditions of the skin, which may develop from two to four weeks after vaccination. In these cases the vaccination would be without pathogenetic influence, were it not for the predisposition to eruptive disorder constituted by the peculiar diathesis, the existence of which is a necessary condition of its operation.

A large proportion of the pustular eruptions which are identical in character with the vaccine lesion, are directly traceable to auto-inoculation, the essential condition of which is an abraded or exposed surface. Their almost exclusive occurrence in persons who have eczematous or other cutaneous disorders at the time of vaccination, emphasizes the importance of a rule of action which was recognized and insisted upon by the earlier vaccinists, but which has since been recklessly disregarded, viz.: that the existence of such a disorder should be accepted as a positive contra-indication to vaccination, except in cases of immediate danger from exposure to small-pox.

The possibility of the occurrence of a generalized vaccinia has been questioned. Analogically, we might infer that a disease capable of impressing the system so profoundly as to extinguish its susceptibility to the variolous poison, which has, besides its reciprocity of action, so many points of similarity, though not of identity, with variola, should, like variola, manifest itself by a general eruption. Besides possessing analogical probabilities, the fact of its existence rests upon the testimony of careful and competent observers, which would seem entitled to credence.

Its explanation is simple : it is a specific product of the vaccine virus, which in these rare cases manifests itself by a generalized instead of a local eruption.

The purpuric eruptions present certain analogies with the hemorrhagic accidents caused by the variolous poison. They may be due to the direct effect of the vaccine virus upon the corpuscular elements of the blood, modifying them in such manner as to favor extravasation, or transudation may occur from diminished vitality of the cutaneous capillaries which renders their walls more brittle and permeable.

As regards the graver forms of vaccinal eruptions, more especially *vaccinia gangrenosa*, I suspect that they have close relations with the erysipelatous, pyæmic, and gangrenous conditions which sometimes follow vaccination, and which are doubtless due to the introduction of a septic, decomposing material in the blood. These accidents, which I propose to consider in a future paper, often imperil the health and life of the patient, and are the more to be deplored since they are in most instances preventable.

Society Transactions.

NEW YORK DERMATOLOGICAL SOCIETY.

133D REGULAR MEETING, JAN. 23, 1883.

DR. E. B. BRONSON, *President, in the chair.*

DR. F. R. STURGIS, bringing before the Society the subject of

ELEPHANTIASIS GRÆCORUM.

said that it had been the good fortune of the surgeons of the third division of the skin and venereal service of Charity Hospital to have had under their care nearly all the cases of this disease that had been in this city of late years. He desired to speak of the etiology of the affection, its derivation, mode of transmission, and treatment. He had had under his care five cases in all. The first was that of an American, who had lived in Cuba, where the disease first appeared. The second case was a negro, the third a Chinaman, and the fourth an old German who was living in Mexico when the disease first affected him, the macular stage being succeeded by the tubercular after he came to this country. The fifth case occurred in the person of a young man born in Maryland who had lived in Bermuda, the disease having appeared on him after his return to this country. There were no cases of the disease among his neighbors or the other members of his family.

No fair history of contagion could be obtained in any of these cases, with perhaps the exception of the first (who died from leprosy in Charity Hospital). While many Norwegian authors believe in the hereditary nature of the malady,

others ascribe it to improper diet, particularly to the use of decayed fish, it being a common custom among Norsemen to wait until their food has decayed before eating it.

Some Hawaiian authors have confounded cases of leprosy with syphilis, and are by no means clear in their notions on the subject, one writer having gone so far as to declare that leprosy is only a fourth stage of syphilis, a view which was, in his opinion, utterly untenable. It is claimed that the disease originated in that country in the person of a Chinaman, who was said to have acquired it through sexual intercourse. In view, however, of the notorious immorality of the women of the Sandwich Islands, the disease has spread far less rapidly in that country than we would expect it to do if it were transmissible in that manner. It has also been shown by the experiments of Danielssen, who inoculated lepers with syphilis, that the latter disease may be communicated to them, and run its regular course, unmodified by the leprosy.

Instances of hereditary transmission of the disease are rather rare. With regard to inappropriate diet as a cause, he did not believe that that could be invoked to any great extent. The Chinese are careful in their diet, eating principally of rice, yet they are prone to the disease.

In temperate and northern climates, the type of the disease is undoubtedly milder than in tropical regions, such as Japan, Singapore, China, and the Strait settlements, where the affection usually passes rapidly from the macular into the tubercular variety, and is attended with extensive ulceration and dry necrosis of tissue.

In order to limit the spread of the disease, sequestration has been practised for several years in the Sandwich Islands, all cases of it being confined to the Island of Molokoi from which there is no escape. Two thousand cases have thus far been received there. They are cared for by Catholic missionaries, who probably pay but little attention to the medical treatment of the malady.

In the West Indies, lepers are also attended by missionaries, by whom a variety of remedies have been much used. They believe, as a rule, that the disease, if treated early enough, is curable. Although beneficial results have been obtained in this country, it is still an open question whether it is or is not curable, in the strict sense of the word. In a number of cases treated here, decided amelioration has been produced by the use of chaulmoogra oil and Hoang-nan. The first case alluded to this evening seemed to improve under the use of both of these drugs, doing best under the combined internal and external use of the oil. In the case of the Marylander, improvement followed the use of Hoang-nan, but the oil did no good. (The latter case is the first in which he [S.] had seen the development of the so-called "leprous fever.") The patient was one day seized with a chill, and his face and body became very hot, and the seat of an intense erysipelatous redness. The attack was supposed to be of a malarious nature, and quinine was administered. He soon had a second similar attack, after which a number of fresh tubercles broke out, and the nature of the illness became clear. The use of Hoang-nan cut the attack short.

DR. H. G. PIFFARD said that the first case that he saw came under his observation in 1864, at Bellevue Hospital, and two years later he saw a second case. At one of the earliest meetings of this Society, these two cases and two others were present. The first two patients are now dead. The third was a half-breed Cuban, and the fourth case, presented by the late Dr. H. D. Bulkley, was a native of the State of New York, and had never been outside the State. All present pronounced it a case of leprosy. (Among those present was Dr. Wm. Boeck, of Christiania, Norway.) This was the only case with which he was

familiar that had never lived in countries in which the disease was endemic, and was never in contact with other cases of the disease.

Dr. Atkinson, of Baltimore, has recently reported a case that has never been out of this country, and the patient, whose photograph he showed, came to this country seventeen years ago from Norway, the disease breaking out on him seven years ago. Both these cases, however, were proved to have been in contact with other lepers before the disease appeared on them.

It is of great importance to find out whether this malady is contagious, and, if so, in what manner the contagion is conveyed. When this question was investigated by the English Royal Committee in 1868, the majority of the members came to the conclusion that it was contagious, while others denied this. Two years ago, he (P.) had expressed his belief in its contagiousness, and Dr. White, of Boston, has recently done likewise. This view is also held by many other prominent investigators. The question of the bacillus lepræ being the cause of the disease must, he thought, be regarded as still *sub judice*, even if its existence be held as proved. It seemed to him that it is perhaps nothing more than an indication of the disease, something which may aid in the diagnosis.

In his opinion, there is no doubt of the infectious nature of the disease, and that it is transmitted by the blood or secretions of a leper gaining entrance into the blood or tissues of another person, whether during sexual intercourse or not being still undetermined. There is, however, no evidence to show that the poison of leprosy possesses this penetrative power in the same degree as syphilis, which may, as we know, be acquired by one who has no apparent lesion of the surface.

It has been known for many years that the nervous system is seriously affected in leprosy. As bearing upon treatment, it is important to find out whether the disease first involves the nervous system or the skin, and if the former, whether the peripheral or the central. It is, however, a fact, that the nervous system is implicated at a very early period of the disease. Treatment should, therefore, primarily be directed to lesions of this part of the body. The drugs mentioned by Dr. Sturgis are the most valuable known, and there can be no question but that they have done great good.

But little is known of the physiological action of chaulmoogra-oil, but hoang-nan is known to be a neurotic drug, par excellence. Investigations have led to the suspicion that it is the bark of the *strychnos nux vomica*. *Nux vomica* has been found of value in the treatment of leprosy. He had used it in one of the cases mentioned by Dr. Sturgis, and had found its effects on the disease to be substantially the same as hoang-nan (the same alkaloids are contained in both drugs).

Everywhere that this disease has gained a foothold it has spread, and he therefore regarded isolation of cases of it as of the utmost importance. This is very well carried out in the Sandwich Islands, and has been tried in India. It is, however, very difficult of thorough execution. He thought that it ought to be tried in this country.

Dr. FOX mentioned three cases of the disease which Dr. Sturgis had not spoken of. One was an American sailor who had lived in the tropics, the other two were instances of the macular variety; one a patient of Dr. Sherwell, and the other a New Englander who had lived in Central America. He was much benefited by arsenic.

Dr. S. SHERWELL desired to speak only of the etiology of the affection, and to express his belief that great importance should be ascribed to decayed fish as an article of diet as a factor. This he thought justified by the circumstance that the vast majority of the cases occur among dwellers along the seaboard of various countries, nearly all of whom are, of course, large consumers of fish. The fact that in India the disease is common in the interior might seem to diminish the importance of this aspect of the matter, but even there the majority of the cases occur along the banks of the great rivers, where the principal article of diet is doubtless also fish.

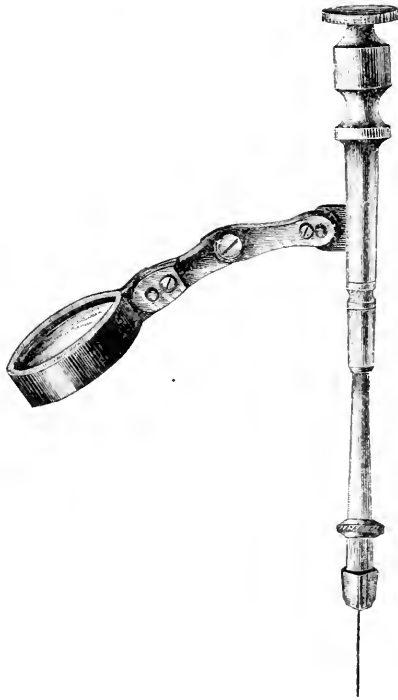
Dr. STURGIS said that he had forgotten to mention another case of leprosy, in the person of a sailor, an inmate of Sailor's Snug Harbor, who had been supposed to have syphilis. About thirty cases in all have been seen in New York during the past twenty years, of which number Dr. Piffard had seen twenty, and he himself twelve. The disease seems to be on the increase in the United States. He had received letters from Drs. Hansen and Ole Bull, alluding to its spread in Minnesota.

DR. PIFFARD exhibited

AN IMPROVED INSTRUMENT FOR THE REMOVAL OF SUPERFLUOUS HAIRS,

And stated that, in 1876,¹ he had called attention to a method that he had employed for the permanent removal of hairs in cases of hairy nævus. At the time he was not aware that Michel, of St. Louis, had a few months previously given an account of the same procedure (electrolysis) in connection with the destruction of the hairs in palpebral trichiasis. In 1878, Hardaway reported that he had employed the method successfully in cases of hirsuties of the face in women. Fox has also reported similar good results. Personally, he had operated in a number of cases with varied result, but had declined to operate in a still greater number.

Female facial hirsuties appearing between the 20th and 30th year, does so as



the result of some pre-existing cause. If this cause can be detected and abated, it is judicious to operate. If it cannot be abated and is still active, destruction of the larger hairs permits the finer ones to more freely develop, and success may not be expected until every hair follicle on the affected surface has been destroyed. At least this was the conclusion that he had personally arrived at. There are, however, a certain number of cases in which good results may be obtained by the expenditure of a moderate amount of time and trouble.

The hairs themselves are of different sizes, the larger ones being plainly visible, and when extracted, the openings of the follicles can be seen by average eyes with sufficient distinctness. There is no difficulty in dealing effectively with them.

¹Elementary Treatise on Diseases of the Skin, p. 307.

In addition to these, however, there are many hairs so fine that it is not practical to attempt their destruction with the unaided vision; an amplifier of some sort becomes necessary. In his earliest experiments, he made use of a cumbrous and and inconvenient compound microscope fitted with an erecting eye piece, and adapted to a stand specially constructed. This was effective but inconvenient, great loss of time occurring in making the requisite adjustments for almost every hair. He next tried an ordinary jeweler's glass; afterward a very small (one inch long) compound microscope fitted to a spectacle frame. This was also unsatisfactory, and for a long time he had been without an amplifying arrangement that was not on the whole more troublesome than useful. Quite recently, however, he had had constructed the instrument here shown.

The needle holder is the one he had long used and elsewhere¹ described, to which a simple lens has been attached by means of a jointed and adjustable arm. The sort of lens to be employed is not a matter of indifference. An ample and a flat field are requisite, that is to say, the spherical aberrations must be abolished. This is almost impossible in a simple non-achromatic double convex spherical lens. It is quite possible, but by no means easy, however, to obtain the requisite flatness of field with a properly corrected achromatic lens. The lens employed in the present instance, however, possesses certain practical advantages over an achromatic. It is a double convex cylindric in which the axes of the two cylinders are at right angles. The principal focus of this lens is a little less than four inches, giving when in use a working distance of about $2\frac{3}{4}$ inches.

The advantages of the instrument as a whole are that it brings into good view parts that were previously invisible or were but dimly seen, and thus enables the operation to be more thoroughly and accurately performed, and of course extending its practical usefulness.

It need hardly be stated that the idea of attaching the lens to the needle-holder was in part suggested by the clever little instrument devised by Bergh to facilitate the search for the *acarus scabiei* (see this JOURNAL, p. 154).

DR. FOX said that, although the instrument seemed a very ingenious one, he doubted whether it would prove of much service in the operation for which it was invented, in which practice and a certain dexterity were the essential requisites. He was confident that he could remove, by the aid of the naked eye, any hair that was annoying to a patient. In some cases the original cause of the hirsuties, whatever it might be, had ceased to exist, and in such the small hairs would not grow large enough to be objectionable.

DR. BRONSON spoke of a case where the reproduction of hairs was very rapid. He removed them on one side of the face, and before he had finished the other side, they had grown again. He agreed with Dr. Fox that success in the operation was more dependent upon dexterity, upon introducing the needle in the right manner into the follicle, than upon acuteness of vision.

DR. PIFFARD said that in his paper the possession of dexterity was presupposed. He thought that in those cases in which the cause of the trouble was still operative, the procedure was unjustifiable. There were three methods of operating, 1st (that which he adopted), to extract the hair and then introduce the needle into the empty follicle; 2d, to introduce the needle into the skin outside the follicle, in the direction of the papilla, and then after electrolysis extract the hair; and 3d, to pass the needle alongside the hair while it was still in the follicle (Fox's method).

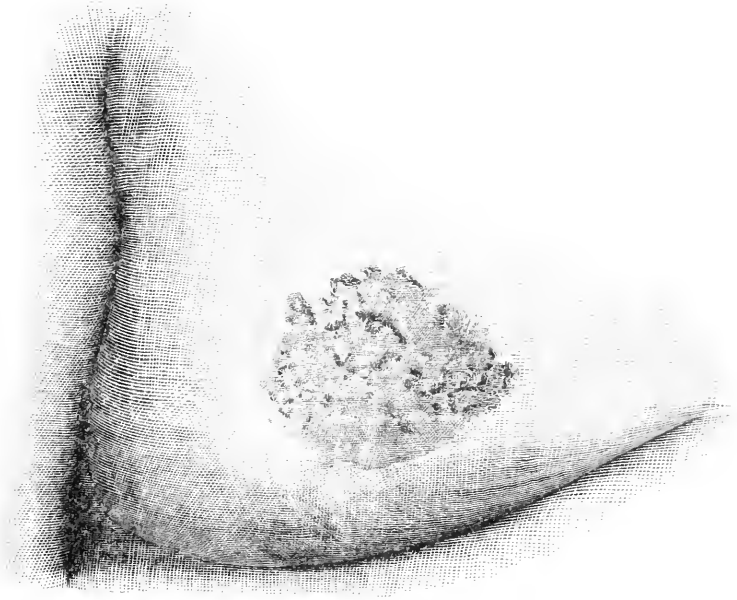
DR. SHERWELL exhibited a case of

PAGET'S DISEASE OF THE NIPPLE.

The patient was a woman aged forty-seven. The disease began two and a half

¹Materia Medica and Therapeutics of the Skin, p. 334.

years ago, she having hitherto always enjoyed good health. She complains of burning and itching sensations in the part. The patch is of an irregularly oval shape, about $1\frac{1}{2}$ by $2\frac{3}{4}$ inches in size, of a bright-red, succulent appearance, covered with fine scabs. The nipple is so far retracted as to be much below the level of the breast, and presenting a moist exuding surface. The edges of the patch are sharply defined and slightly elevated. No induration can be felt in the gland, nor under the diseased surface.



DR. PIFFARD thought the case undoubtedly one of "Paget's disease," and advised the destruction of the patch by some reliable caustic paste, such as potassa cum calce, or sulphuric acid and charcoal, or a mixture of chloride of chromium and chloride of zinc. Of these the latter would probably cause the least pain.

DR. TAYLOR would recommend a more radical procedure, viz., the removal of the entire breast, fearing that caustic pastes might not penetrate deep enough.

DR. BRONSON was in favor of a less radical course, preferring to treat the case as an ordinary eczema rubrum. He alluded to a paper by Napier, in which was described a similar case of two years' standing, in which excision was advised, but declined, the case afterwards recovering entirely under ordinary treatment for eczema. Brush has written in the same strain, and has shown that mild treatment has often cured the disease. This author believes that in many cases the extension of the disease in the malignant form is due to the fact that the collection of scales on the surface causes the prickle cells to grow downwards into the tissues of the glands. He therefore takes great pains to prevent the accumulation of scales on the surface of the patch.

DR. SHERWELL alluded to another case of the same disease which he had under observation. The patient was seventy-five years old, and the disease had lasted twelve years.

Selections.

THE OLD AGE OF THE SKIN.

THE alterations in the condition of the skin incident to old age are divided by the author into two principal classes; the first of these includes the functional and structural changes which constitute what is called atrophica senilis of the skin, changes which affect every individual during senescence in a greater or less degree, and which are to be regarded, therefore, as a natural process of decay. The second class comprehends certain alterations in its tissues and disorders in its economy, which must be regarded as pathological processes characteristic of this period of life, although not peculiar to it. The hair follicles are generally the earliest to exhibit indications of the first-named condition, but senile forms of calvities and alopecia often show themselves in middle or even early life—manifestations, it may be, that this appendage of the human skin is in process of gradual race extinction upon those parts of the surface also where it still attains its full development. The changes which occur in early forms of baldness, not dependent upon positive disease of the cutaneous tissues, and in premature blanching of the hair, are the same as those which occur in advanced age, and which are often accompanied by other and marked alterations in the structure of the skin.

The appearance of the skin in an old person differs physiologically from that of infancy and adult life in that it is generally thinner, drier, paler, rougher, more wrinkled, and in parts inclined to exhibit discolorations and excrescences. The roughness is due to a change in the character of the epidermic cells, by which they lose the power of individual desquamation, and collect in masses in places like reptilian scales. This is especially noticeable upon the backs of the hands and face. With this thickening, there is often associated an excessive formation of pigment, both in its diffused and granular state, frequently giving rise to marked deep-brown or black discolorations of considerable extent. The thinning of the skin is due to a shrinkage in all three of its layers. In a particular form of degeneration, the whole fibrous skeleton of the cutis is converted into a structureless mass, which is brittle and easily split or fissured, the so-called hyaline, amyloid, colloid, or glassy degeneration.

Of the pathological changes in the skin characteristic of old age, the most important may be described as follows:

Pruritus Senilis.—This is a purely subjective condition of the integument, not attended primarily by any perceptible changes in its structure. The principal sensation is an intense itching, sometimes with a feeling of burning or formication. Scratching is invariably resorted to for a relief to the suffering, and is performed at times with intense frenzy and until a pitch of general nervous excitement is induced resembling the sexual orgasm. As a consequence, the skin sooner or later undergoes various changes in its tissues, its surface presenting scratch marks of different depths, with inflammatory lesions of all grades. The hairs upon the extremities are often worn off, and the skin thus attains a harsh feeling and eventually assumes a dark hue. The seat of the pruritus is chiefly the extremities, especially the legs, but the genital region is frequently affected, and becomes the seat of intense suffering. It is not surprising that with the

sleeplessness and constant peripheral nerve agitation attendant upon this disease, it should at times eventually lead to disturbance of the central nervous system and intellectual faculties, and thus react upon the whole economy.

In the treatment of pruritus senilis all grades of eczema may demand their proper care before the case is reduced to one of simple pruritus, and sometimes mechanical aids to self-restraint are absolutely necessary. Among the most reliable remedies are carbolic acid, tar, chloral hydrate, camphor, corrosive sublimate and hydrocyanic acid, which may be applied in various forms, and at times be combined with advantage. In order that any of these compounds may not lose their effect by prolonged employment, it is well to change from one to another after a time. Stimulating articles of food and hot drinks are to be prohibited, as well as alcoholic liquors after the noonday meal. The patient is not to be permitted to approach the fire, particularly at night. If necessary, the feet may be warmed before going to bed by a foot-bath. The thinnest old linen or cotton garments should be worn next the skin beneath the ordinary woollen shirt and drawers.

Purpura Senilis and *Pigmentation* call for only a passing notice. The former is the result of simple loss of vitality during senescence, and does not differ from the simple purpura of earlier periods of life except in its more persistent recurrence. It is to be controlled mainly by such mechanical agencies as rest, a horizontal position for the legs, and the constant use of the elastic stocking or rubber bandage. Pigment spots, when not forming the beginnings of more serious disturbances, may continue to extend or last indefinitely as a harmless disfigurement only, for whose removal no treatment is necessary or possible.

Disorders of the Sebaceous Glands.—The sebaceous glands, when retaining their activity late in life, often secrete in some parts a modified sebum of a cheesy consistence, which forms upon the scalp a continuous firm coating, gradually changing by the retention of dirt to a brownish or black color, and presenting a most unsightly appearance. Similar concretions sometimes form also about the openings of the glands of the face. They are not always to be easily distinguished from other affections of the glands in which a modified cell-growth is transformed into an epitheliomatous neoplasm. All such simple collections of sebum may be readily prevented from forming by proper care of the skin, and are easily removed. The scalp should be saturated with sweet oil for half an hour or so daily. A bit of sponge or flannel rag smeared with toilet soap, or dipped into a strong solution of soft soap in alcohol, should then be rubbed into the part, gradually adding water until a thorough lather is obtained. This mixture of fatty scales, oil and soap is then to be thoroughly rinsed off with much water, and the scalp smeared with lard or vaseline. This is to be repeated daily until the accumulation is entirely removed and ceases to form again. Afterwards the scalp should be washed often enough to keep it active and clean. Upon the face and other parts the concretions may be smeared at night with an ointment (hydrarg. am. chlor., \odot i., vaseline, $\frac{3}{4}$ i.), and treated in the morning with oil and soap, as above directed. This course is to be followed until the glands involved return to their healthy action.

Keratoses Senilis.—This affection first showed itself in the form of collections of scales, hardly elevated above the general surface, of somewhat darker color than the surrounding skin, of an irregularly circular or oval outline, resembling freckles of light tint. Attracting little attention at first, they gradually become more noticeable by increase of thickness and depth of color, but their development is very slow, and years may pass before they have attained sufficient growth

to become troublesome. In their most advanced condition they present elevations an eighth of an inch above the general surface, consisting of dry, horn-like scales, which vary in color from the faintest yellow to the deepest black, and which may be removed with a little violence with the nail or a blunt-edged instrument, leaving exposed a superficial excoriation. When fully developed they may be a third or half an inch in diameter, and they have generally a flat surface. They may occur singly or in considerable numbers upon the face or hands. They rarely appear in great numbers before the age of fifty, and are seldom very conspicuous before that of sixty-five or seventy. They are much less likely to develop upon persons who have kept their cuticle and sebaceous gland in proper order through life by sufficient use of soap than upon those who have neglected this custom.

The prognosis in these cases is generally most favorable if treatment is resorted to in good time. But the most simple changes in the cutaneous tissues of the face in old people are always to be held under suspicion; and this affection is the starting-point of a large proportion of superficial cancers (rodent ulcers) in the aged, the transition being very gradual and unmarked by any striking change in the condition of the part.

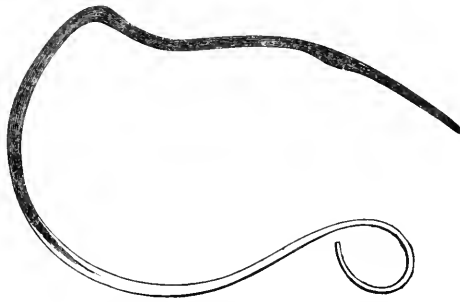
In the earliest stages of this affection it will be sufficient to wash the parts daily with soap and water, and the use of a little sweet oil rubbed into the patch and allowed to remain a few minutes before applying the soap, will make its removal easier. When the growths are thicker and firmer, and when there is much pigment change, it is well to use upon them over night some fatty material like lard, or diachylon ointment in the form of a plaster, and to rub into them in the morning on a piece of flannel cloth some of the strong soaps, like domestic soft soap or *sapo viridis*, or their concentrated solutions in alcohol. Water is next to be rubbed in until a thorough lather is made, which is then to be washed off. Should any excoriations be thus produced they may be protected by a patch of cloth spread with diachylon plaster until healed. If the epidermal masses are unusually prominent, or if the sebaceous glands are involved to any great degree, concentrated nitric acid may be repeatedly bored into the underlying tissues upon a sharply-pointed stick, or the sharp spoon or curette may be used to scrape out at once all diseased elements, as soon as any suspicion of transition to epitheliomatous growth arises, the part should be dealt with according to the rules for treatment in that affection — WHITE, *Boston Med. and Surg. Journ.*, Nov. 23, 1882.

CASE OF PARASITIC AFFECTION OF THE MOUSTACHE.

THE following interesting case which occurred in my practice is worthy of record for several reasons.

In April, 1876, a gentleman, aged about thirty, consulted me on account of loss of hair in one part of the moustache, a little to the right of the nose. He had recently returned from residence abroad, but was in good health, and very careful of his person. His strong black and handsome moustache was disfigured by a bald strip about a quarter of an inch broad, which passed from its upper to its lower border. The hairs on both sides of the bald strip were split at the ends, and were bent and withered-looking. On examining these altered hairs under the microscope, they were found to contain spores similar in size and appearance to those of *trichophyton tonsurans*. The disease of the hairs had existed, he told me, for five months. I directed him to brush his moustache twice daily with the following preparation: Carbolic acid, one drachm; olive oil, two ounces and a half; lavender oil, six drops. In less than a month the disease had

disappeared, and the bald part became again covered with healthy hairs. But the singular part of the history is to come. The disease was first observed in November, 1875. It reappeared in November, 1876, and every succeeding November until 1880 inclusive. Last November, for the first time since it commenced, it did not reappear. During the successive outbreaks, the nature of the disease was verified by microscopic observation. In the attacks subsequent to the first the carbolic oil was used four times stronger than I originally prescribed it, and always with the speedy cessation of the loss of hair. The skin from which the hairs fell off remained healthy in appearance, showing no redness or scaling, or any signs characteristic of *tinea circinata* or *tonsurans* or of parasitic sycosis.



Hair from moustache affected with fungus growth (conidia), macerated in solution of potash, and mounted in glycerin. The dark part shows the portion of the hair in which the spores were present. Magnified five diameters.

The two points that have led me to consider the case as remarkable are, first, the position of the fungus in the hair; and, secondly, the reappearance of the disease in November for five successive years. In regard to the position of the fungus, the direction of the growth is different from that which I have observed in *tinea tonsurans*. In that disease, the fungus grows into the hair-follicle between the hair-shaft and the internal root sheath, enters the shaft near the papilla, and grows outward in the centre of the shaft. In this case the fungus attacked the free extremity of the hair, and grew downwards towards the skin. This is shown in the accompanying woodcut, which represents a drawing of an affected hair slightly magnified. In the woodcut, the dark end is the free extremity of the hair, and represents the portion of the shaft affected with the fungus. The tapering extremity of the dark band in the centre of the hair accurately represents the manner in which the growth is found penetrating the shaft. Why this disease should have recurred each successive November can only be guessed. We must, I imagine, assume that some spores remained from each year to the following year, and that in November they found the conditions of growth. The parts of the hairs in which they grew were completely removed from the fluids of the body. Did they find in November the conditions of temperature and moisture suitable to their growth? The patient during these years enjoyed good health, lived in London, and led an active professional life.—GEO. THIN, *Lancet*, November 4, 1882.

ANIMAL VACCINATION.

THE article begins with a sketch of the history of animal vaccination in the United States, which is followed by a consideration of the causes that have led

to its being at present held in lower esteem than formerly by the profession. This, it is maintained, cannot be attributable to any degeneration of the stock of vaccine used by the older producers—namely, the Beaugency stock. “The conclusion is inevitable that a great deal of the bovine virus used in this country during the last four or five years has not been of good quality.” The idea which has been proposed, that the production of animal vaccine should be carried on by the Government, and that the commodity thus produced should be furnished to physicians gratuitously, is denounced as not only opposed to the genius of our institutions, but as one which, if carried out, would result in no real advantage. Government *supervision*, however, whether conducted by the national authorities or by the several States, “might be productive of great benefit to the medical profession and to the whole community.”

Meanwhile, it is urged that many of the abuses which have sprung up in connection with the business of supplying vaccine might be abated if physicians would act in accordance with the following considerations:

1. Those who prefer animal vaccine under any circumstances should use it under all ordinary circumstances. On the other hand, those who prefer humanized vaccine should, whenever they think proper to use the animal virus, bear in mind that success with the latter is to a great degree dependent upon certain details in the mode of its employment, notably, that it should actually be transferred to the abrasion, which transfer, on account of the great tenacity with which it clings to the slip, is not so rapidly accomplished as that of humanized lymph under like conditions.

2. As at present furnished, all forms of animal vaccine, except dried lymph, are little better than worthless; therefore no other form than the latter should be used.

3. It is by all means advisable always to obtain one's supply directly from the producer or his accredited representative. The practitioner should make it a point to know who the man is that actually does the work of producing the virus he is to use; and the choice of material, as between different men's productions, should not be governed in the slightest degree by the difference in their prices.—FOSTER, *N. Y. Med. Journ. and Obst. Rev.*, Nov., 1882.

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Studii ematologici nei Leprosi dai DOTTORI MAJOCCHI e PELLIZZARI. (Reprint.)

Reinfektion Sifilitica in due Coniugi pel DOTT. CELSO PELLIZZARI.

Items.

POISONING FROM THE LOCAL APPLICATION OF PYROGALLIC ACID.—BESNIER (*Ann. de Derm. et de Syph.*, Dec., 1882) records four cases of poisoning, two of which were fatal, following the external application of pyrogallic acid in the treatment of psoriasis. These cases occurred under the care of Neisser, Pick, Vidal, and himself. In all of them, hematuria or hemoglobinuria was a prominent symptom.

CENTRALBLATT FÜR DIE GESAMMTE THERAPIE.—We have received the initial number of this journal, edited by Docent Dr. M. Heitler, of Vienna. He is assisted by collaborators well known in science, among whom we note Jarisch, Kaposi, and Neumann, which we take as an indication that dermatological therapeutics will receive its share of attention. In this first number, indeed, we find an article by Jarisch depicting the present status of chrysarobin, pyrogallol, and naphthol as cutaneous remedies.

DERMATOLOGY IN AMERICA.—It is altogether likely that for many years to come the lustre of the late Professor Hebra's fame as the practical founder of modern dermatology will not be dimmed appreciably by the achievements of any other one man. Nor are we unmindful of the steady and effective work that has been accomplished by Sir Erasmus Wilson. But, however prominent an individual may stand out, a less glittering, but on the whole a more substantial, advance in science usually has to be brought about by the concerted labors of the great throng of lesser note. Cutaneous medicine is no exception to this rule; it takes a step forward here, and another there, and its progress, thus insensibly worked out, is among the most solid of the improvements with which the medicine of the present day is to be credited.

Our country may justly claim to have done its full share, and to be doing it still, in this work. It is no more than their due, and a fitting recognition of their painstaking efforts, that the attention of the profession should be called, although not for the first time, to something of what American dermatologists have done. The late Dr. Henry D. Bulkley gave many years of what time he could snatch from the daily duties of a family practitioner to the study of diseases of the skin, and left behind him an invaluable collection of clinical records—data that have since been turned to good account. Dr. Bulkley also gave lectures on dermatology from time to time, and brought out a translation of Cazenave's book. The crowning work of his life, however, was the part he took in founding the New York Dermatological Society, a few years before his death.

This society has flourished from the outset, and its monthly meetings have al-

ways brought together a goodly assemblage of men earnest in their devotion to dermatology. But little of its work has taken the form of set essays, and it has steadfastly steered clear of the whirlpool of debates on classification. For the most part, its meetings have been given up to the observation and study of actual cases of skin diseases, and it is doubtful if anywhere else in the world can so many rare cases, puzzling cases, of diseases of the skin be seen in the course of a year as at these meetings.

The American Dermatological Association, although laboring under the disadvantage of meeting but once a year, and necessarily dealing more with formal papers than with clinical work, has yet a most creditable record, as may be learned from its volumes of transactions. Although a younger organization than the New York society, it has accomplished a great deal, mainly in the opportunity it has given for dermatologists from various parts of the country to profit by that wholesome attrition that accompanies the occasional concert of action by men who are to a great extent strangers each to the other's peculiarities of mind and training.

Shortly after the formation of the New York Dermatological Society, *The American Journal of Syphilography and Dermatology* was established, and its quarterly publication was kept up for four years, with credit to the editor and with profit to the branches of medicine to which it was devoted. At about the time its publication ceased, the issue of *The Archives of Dermatology*, another quarterly, was begun. That journal has contained some of the most notable contributions to dermatological literature that have appeared since its establishment. With the number for October, 1882, without having shown the slightest sign of decadence, its existence ended, simultaneously with the appearance of a new monthly journal, *THE JOURNAL OF CUTANEOUS AND VENEREAL DISEASES*, a handsome and promising journal and one which already gives good grounds, in the few numbers that have been issued, for the hope that it may long continue the good work done by its predecessors. Thus at no time during the past twelve years has dermatology been without its special literary repository in this country, to say nothing of the admirable text-books, colored plates, and photographic portraits that have been produced by American authors.

The didactic and clinical teaching of dermatology has come to be a regular feature in the courses given at our leading colleges, and the interest shown in various private courses of instruction gives evidence that it is not alone among our specialists that the study of diseases of the skin is duly followed, but that the field those diseases afford for general pathological investigation—being, so to speak, an epitome of general pathology—is appreciated by a large proportion of the profession as a body.

Although many of our best-known dermatologists doubtless caught their first enthusiasm in Vienna, they have no more yielded themselves up to the peculiar etiology taught by Hebra than to the opposing views of that have been enunciated so persistently and so ably in France. Neither the one nor the other of these disturbing influences has dazzled them, and we may well question if it is not to this independence of thought, this unprejudiced study of the natural history of skin diseases, that we owe the present satisfactory and promising state of dermatology in this country.—*New York Medical Journal*, Jan. 13, 1883.





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ERYTHEMA DIPHThERITICUM.

BY

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IN some cases of diphtheria, a rash appears upon the skin, which possesses sufficient special characters to warrant a brief description.

The skin becomes affected under two conditions, viz., either in the early stages of the disease, or at a later period in some cases of severe blood-poisoning; and though in both instances the rash is of an erythematous character, yet it is so dissimilar in appearance and course as to demand a separate description.

Early eruption: Sometimes at the commencement of the diphtheria, sometimes as late as the second or third day, a diffuse erythematous rash of variable extent appears upon the skin. It may occupy only a portion of the trunk or extremities, or it may cover the greater part of the body. When appearing as patches of limited extent, it is seen most frequently upon the anterior surface of the thorax or abdomen, though it is frequently present upon the extremities. It is rarely seated upon the head.¹ In color, the rash is from a bright-red to a pale-red; the bright scarlet-red of many cases of scarlatina is, however, rarely observed. In some cases, the rash is not a diffused erythema, but presents a mottled appear-

¹This description is only intended to apply to the cases observed by myself, the number reaching perhaps one hundred in which the early erythematous rash was observed.

ance, as is observed in many cases of scarlatina, normally colored skin alternating with pin-head sized erythematous spots. The redness easily disappears upon pressure. If the eruption is limited in extent, the patches are of irregular outline, and not perceptibly elevated above the general surface.

The outbreak of the eruption is not accompanied by special elevation of temperature, and there is no burning or itching produced by it. After the first few hours, the eruption usually does not increase in extent. After existing twenty-four to forty-eight hours, it disappears, without being followed by desquamation. In a prognostic sense, it has no significance, as it is met with as frequently in mild as in severe cases of diphtheria. It bears some resemblance to the prodromal rash of variola—erythema variolosum—and neither the character nor the distribution of the erythema enables us to predict the severity of the diphtheritic disease.

Diagnosis.—The only eruption with which it can be confounded is that of scarlatina; and owing to the varied character of the erythema of this disease in different cases, it is often exceedingly difficult, and sometimes impossible, the first twenty-four hours to make a correct diagnosis. Generally, the scarlatinal rash is of a brighter-red color, and is accompanied by considerable increase of fever and general disturbance of the system. There is also an early and general bright redness of the throat and changes in the mucous membrane of the tongue. As regards the distribution, the scarlatinal rash generally commences on the neck, and spreads over the whole body, being especially developed on the extremities, the lumbar region, and the lower part of the abdomen. Its disappearance is also followed by desquamation. In the erythema diphtheriticum just described, there is no marked elevation of temperature, the rash may commence in any region, and rarely extends over the whole body, the tongue is not affected, and there is no special disturbance of the general system. The scarlatinal rash, however, is so variable in its character, and may simulate the erythema of diphtheria so closely, that the diagnosis sometimes cannot be made until it is seen whether desquamation occurs or not.

Rash of septic diphtheria.—In some cases of septic diphtheria when the blood is poisoned by absorption from the diseased mucous membranes, an erythematous rash appears which presents many of the characteristics of erythema multiforme. It appears only when the diphtheria has already existed a few days, and its presence indicates that the system is more or less profoundly affected by the diphtheritic septicæmia.

It is met with in both pharyngeal and nasal diphtheria; but as extensive blood-poisoning occurs most frequently when the nose is the part affected, so the rash appears most frequently in connection with it.

Situation.—I have observed it most frequently upon the extremities, but it may appear upon any part of the body. After the extremities, I have observed it most frequently upon the anterior surface of the abdomen. Generally, it is limited in extent, but may be general over the whole body.

Characters of the eruption.—It commences as pin-head sized or larger erythematous raised spots of a bright-red or rose color, which disappears on pressure. A large number of such spots may make their appearance simultaneously, or within a few hours, on the same or on different parts of the body. They all possess the same characters, are raised above the general surface, are sharply limited, and are of a red color, which disappears upon pressure. Each spot soon commences to spread peripherically, and generally after they have reached the size of a three-cent piece become depressed or cyanosed, or paler in the centre. They continue to increase in size by spreading peripherically, and at the same time the centre continues to return to a normal condition, being at first of a bluish color, and afterwards normal in appearance. In this manner, rings are formed consisting of a raised, red seam similar to the first spots, and a cyanotic or pale centre—*erythema annulare*. If the ring has attained, say, the size of a dollar, then the very centre will be perhaps normal in color, and then more externally cyanotic, and the peripheral part red. These rings may increase in size until they reach several inches in diameter, the red seam generally not being wider than one-third of an inch in diameter and sharply limited externally. At the same time that these spots are spreading peripherically and forming rings, new spots are arising, so that, as in the plate, a multiform erythema eruption is seen, in which pin-head sized spots, and all gradations between them, and rings, perhaps several inches in diameter, may be met with. The rapidity with which the erythema spreads varies very much in different cases and in different spots on the same individual. Sometimes they spread very slowly, requiring two or three days to reach any considerable size, and I have seen a ring three inches in diameter form in fifteen minutes. This great rapidity of formation is very rare. In the case in which I observed it, the process was very interesting. Spots would arise, and in a few minutes spread peripherically and form rings which, after a few hours, would disappear, and be followed by the same process on perhaps the same place as a previous ring had existed. If neighboring rings, by spreading peripherically, run into each other, the red seam at the place of contact disappears, and irregular figures with serpentine margins are formed—*erythema gyratum, figuratum*. In the accompanying drawing, there are several such figures, some of them being composed of the union of several rings. On dependent parts of the body, the spots do not clear up as much in the

centre as in other places, so that instead of rings there are large erythematous patches with bright margins and a somewhat cyanotic centre. In every case, the eruption is elevated above the general surface, and the margin slopes to the normal skin. The eruption does not itch or burn, and its disappearance is not followed by desquamation. Occasionally it leaves a slight brown pigmentation.

The eruption does not always follow the course here described, sometimes patches arise which spread peripherically without clearing up in the centre, producing large, irregular, raised erythematous patches. At other times, an erythematous eruption exactly similar to that of measles, but limited in extent, is observed. This latter form I have seen especially developed in some cases of scarlatina complicated with diphtheria.

Duration of the eruption.—In fatal cases the eruption continues until death; new spots frequently arising, or the old ones, after reaching a certain size, remaining as elevated reddish rings or patches.

Prognosis.—In the majority of the cases in which this form of eruption appears the blood is very much poisoned and the disease is often beyond the control of the physician. Occasionally by judicious treatment the patients recover, but the appearance of the eruption generally signifies a fatal termination. I here take the opportunity of saying that I have used phenic acid subcutaneously in cases of blood poisoning both in scarlatina and diphtheria and have not obtained the least amelioration of the septicæmic symptoms from its use.

I have seen about thirty cases of this septicæmic rash and they all presented the above described characters of an erythema multiforme. Prof. J. L. Smith informs me that his experience has been similar to my own.

The notes of the case from which the illustration was made are as follows :

Male, one year old, pharyngeal and nasal diphtheria with a large amount of ichorous discharge from the nose. Sixth day of the disease, the eruption on the skin appearing on the fourth day. Situation of eruption—on the face, forearms and legs. Appearance—erythematous patches variously sized, round, irregular, oval, circular or ring-shaped, the redness disappearing upon pressure. Size of the spots or patches—pin-head to patch six inches in diameter, oval or irregular in shape; smaller patches are elevated with sharply defined margins, periphery redder than centre; after a short existence the centre becomes much paler, the periphery retaining its color. The diameter of the red periphery often diminishes with the increase in the size of the patch. As the centre becomes paler there is often diminution in the elevation of the patch. The eruption always commences as small spots or patches which afterward spread peripherically and frequently coalesce. They sometimes spread very rapidly. On the most dependent parts of the legs the patches have coalesced and do not exhibit the ring form. In many of the patches there is a cyanosed zone between the pale centre and the peripheral red seam. The child died on the eighth day of the disease.

The two forms of eruption here described belong to the angioneurotic affections of the skin. In the erythema appearing at the commencement of the diphtheria there is simply a hyperæmia, a dilatation and distention of the finest capillaries of the skin, a vasomotor irritation of the cutaneous nerves. In the septicæmic erythema the local nutrition changes are greater and the cause of the vaso-motor irritation is a toxæmia, depending upon the presence and circulation in the blood of the septic material absorbed from the diseased mucous membranes; a toxic angioneurosis producing changes in the skin very similar to those of erythema multiforme. Perhaps the latter also depends upon some special condition of the blood.

THE TREATMENT OF URTICARIA.¹

BY

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IT has been wisely remarked that the difficulty in curing a disease is always in direct proportion to the number of remedies which have been recommended in its treatment. Urticaria is no exception to this rule. Its frequent obstinacy is attested by the experience of nearly every physician, and yet there is scarcely an affection of the skin for which so many drugs and local applications have been vaunted, tested and discarded.

Of the treatment of acute urticaria little need be said. The cause is usually ephemeral in character and a purely expectant plan of treatment, though not to be recommended, will be followed in most cases by a speedy return to health. Since the eruption is so frequently due to the ingestion of irritating substances, the main indication for treatment is to evacuate the alimentary canal. The emetic which is so commonly prescribed, though rarely until after the offending substance has passed through the stomach, too often fails to remove the source of trouble and only relieves the eruption by its temporary effect upon the cutaneous circulation. In urticaria *ab ingestis*, particularly in children, a dose of rhubarb and magnesia or of castor oil will usually do far more good than an emetic, since the irritation which provokes the eruption is more frequently intestinal than gastric. In acute urticaria from other causes, treatment consists almost wholly in relieving the distressing pruritus during the continuance of the attack. For this purpose one of a great variety of soothing applications may be selected. In my experience alcohol

¹ Read before the N. Y. State Medical Society, Feb. 7, 1883.

has proved to be the most convenient and beneficial lotion, and to obtain the best results it should be merely dabbed upon the skin with a sponge or soft cloth and allowed to evaporate, the patient being cautioned not to rub the affected parts. For certain patients cologne water may be preferred and the antipruritic effect may perhaps be slightly increased by the addition of benzoic acid. The application of sweet spirits of nitre by means of a feather or brush has been recommended by Clark (*Lancet*, Sept. 18, 1880). Acid lotions also serve to allay itching, and of these vinegar is the one which is most likely to be at hand. Rubbing the skin with a sliced lemon may likewise have a good effect. Dilute hydrocyanic acid has an established reputation as a local application for the relief of pruritus, but dilute nitric acid, according to Startin (*Med. Times and Gaz.*, May 13, 1854), is quite as useful and much less expensive. The dependence of urticarial wheals upon contraction of the cutaneous muscular fibres, as first pointed out by Gull (*Guy's Hosp. Rep.*, 1859), would lead one to regard the local use of chloroform as of probable value and this has been verified by experience. Gull mentions a case of factitious urticaria in which the skin became quickly swollen and stiff with wheals when the face was wiped with a towel or the socks pulled on. When chloroform was dropped upon the skin in this case no wheal could be produced. Nor did any wheal arise when ice was applied after friction. Neligan (*Skin Diseases*, 2d Ed., 1866) speaks of chloroform as an excellent topical remedy to allay the itching. He recommends an ointment prepared by rubbing together half a drachm of chloroform and an ounce of cold cream, which should be smeared rather thickly over the affected surface. Hardy recommends a lotion consisting of chloroform, 10 parts, and oil of sweet almonds, 30 parts, to be applied several times daily.

Carbolic acid, boracic acid, corrosive sublimate, arnica, chloral camphor, veratria in tincture and ointment, and many other antipruritic remedies have been praised by writers on urticaria, but their special value in this disease is questionable.

As to the employment of baths in acute urticaria there is a notable disagreement on the part of authoritative writers, some praising them highly, some condemning them severely on account of their alleged tendency to excite the skin. The effect of the bath doubtless differs in different patients, but in the majority of cases a tepid bath containing a quarter or half pound of carbonate of soda with boiled starch, bran, or oatmeal added, will prove quite soothing to the sufferer. I have repeatedly advised patients with a most intense eruption of acute urticaria to go straight to the nearest Turkish bath, where they have generally found speedy relief. Indeed, the eruption is said to have disappeared immediately after plunging the feet and legs in hot mustard water.

The treatment of chronic urticaria is by no means a simple matter.

Expectancy will not suffice as in the case of acute urticaria. We may wait in vain for spontaneous relief, while the torment of the patient is a constant and urgent demand that something be done—or at least, attempted. Urticaria can boast of a longer list of distinct causes than any other affection of the skin, and success in its treatment must be based upon a knowledge of its etiology, a fact not sufficiently appreciated. Ask a physician what will cure headache, and he will probably reply that it is necessary to know whether it is a nervous, a bilious, a congestive, or some other form of headache. Ask him what will cure urticaria, and in nearly every instance he will mention one or more remedies to which he has pinned his faith, without giving a thought to the widely varying nature of different cases. No wonder, then, that chronic urticaria is a notoriously obstinate affection!

Without attempting a discussion of its etiology, it may be stated that urticaria commonly depends upon functional derangement of some of the abdominal viscera combined with an abnormal excitability of the sympathetic nervous system. Our chief object in the employment of remedies should be to lessen or remove the predisposing cause and to quiet the nervous irritability. The local applications which have been already mentioned may be advantageously resorted to as palliative measures in the treatment of the chronic form of the disease, but to effect a cure we must always depend upon internal medication.

In looking over the rather extensive literature of urticaria and noting the number of various drugs which have been employed in its successful treatment, it is evident that they must act in different ways, and that each one is only suited to a limited number of cases. In fact, urticaria, with its great variety of causes, is the last disease for which a specific remedy should be sought.

A very important class of remedies in the treatment of this affection are those which tend to eliminate from the blood the imperfectly oxidized products of digestion and the impurities resulting from tissue metamorphosis.

The alkalis, which have such a marked effect in purifying the blood and averting the attacks of gout and rheumatism, are extremely beneficial in many cases of urticaria. In like manner, saline purgatives, by promoting the excretory functions of the kidneys and bowels, tend to depurate the system, and thereby to lessen cutaneous congestion.

Bicarbonate of soda is an old and valuable remedy in urticaria, and may be advantageously given in half-drachm doses in carbonic acid water half an hour before each meal. Colehienn has also a beneficial action. Maclagan (*Edin. Jour.*, Aug., 1846) found upon examination of the urine of a patient with severe chronic urticaria that there was a marked deficiency of urea and uric acid, the products of transformation of the tissues,

and thereupon concluded that the cutaneous irritation might result from the retention in the system of matter which ought to be eliminated. Colehium, on account of its power to increase the amount of urea in the urine, was ordered, and in a fortnight a normal condition of the urine was established. The tendency to urticaria diminished at once and disappeared under the continued use of the drug. In certain cases, it is advisable to prescribe abstinence from meat and other nitrogenous articles of food.

Since indigestion is such a common cause of urticaria, another important class of remedies are those which allay irritation of the gastrointestinal tract. Rhubarb in three or four-grain doses may be given before each meal to stimulate the intestinal secretions, with an occasional resort to mineral water. Where gastric irritability is present, bismuth is beneficial. Herbert Everett (*Lancet*, April 17, 1869) advises the use of bismuth in full and continued doses for one month. The administration of sulphurous acid, well diluted, will often produce a speedy effect upon the eruption, probably by virtue of its action in checking the fermentative changes in the ingested food. Shoemaker (*Med. and Surg. Rep.*, May 26, 1877) reports an interesting case of chronic urticaria, occurring in a patient of intemperate habits, who complained of epigastric tenderness and diarrhoea. An anti-dyspeptic plan of treatment with strict dietetic regulations effected an apparent cure in six weeks. Two weeks later the wheals re-appeared suddenly without any assignable cause. The treatment was continued, supplemented by various local applications, but in vain. At the suggestion of Prof. DaCosta, who had once seen a similarly obstinate case cured by drachm doses of sulphurous acid, three times daily, this remedy was prescribed with a continuance of alkaline baths at night. In four days "the effect was like magic," and four months later there had been no relapse. A month ago, a lady of forty came to me from out of town with an urticaria which had tormented her daily for the past six months, affecting head, trunk and extremities. She appeared strong and well, and a tendency to flatulence was the only symptom of indigestion, her tongue being clean and bowels regular. Learning that the ordinary plans of treatment had been tried in her case without avail, I prescribed teaspoonful doses of sulphurous acid, to be taken in sugar and water three times daily. Three weeks later, she came again to the city and reported a most gratifying result. A notable improvement had occurred on the second day after beginning the treatment and during the second week there was not the slightest eruption.

A third class of remedies which have been found useful in the treatment of urticaria are such as act mainly upon the nervous system, and tend to lessen reflex irritability. This class comprises a considerable

number of drugs, most of which have a direct influence upon the cutaneous circulation, and many of which are known to have produced an urticarial eruption.

Quinine, cinchonidia, and cinchona bark, *e. g.*, are reputed to have both caused and cured urticaria; and in many cases of intermittent fever it may be difficult to decide whether the drug or the malaria is the cause of the eruption. When the urticarial eruption assumes an intermittent form, as is not infrequently the case in malarial districts, quinine will doubtless prove a valuable remedy. At the same time, the physician must bear in mind that certain patients display a peculiar intolerance of this drug, and invariably suffer from an urticarial exanthem after a minimum dose has been administered.

Lente (*Med. Rec.*, Nov. 16, 1878) speaks of malarious fever in several instances being ushered in by a profuse and typical urticaria which disappeared quite promptly, whether in consequence of the full doses of quinine administered, or the full development of the febrile paroxysm, it is impossible to say. One patient could predict the fever by the appearance of the eruption. He speaks of another case of chronic urticaria in which ten grains of quinine would be followed by relief for some hours. The eruption would then re-appear, and soon decline upon a repetition of the dose. After five or six doses, he was cured. Bulkley (*Amer. Pract.*, May, 1875) reports of a case of periodic urticaria in which the attacks occurred every evening, at seven. Ten grains of quinine, one or two hours before the attack, effected a cure. Wickham (*Med. Chir. Rev.*, Vol. 1, 1852) mentions several cases of urticaria complicated with severe pain in the joints which were cured by quinine.

Belladonna and atropia may likewise be successfully employed in certain cases. Q. C. Smith (*Pacif. Med. and Surg. Jour.*, Dec., 1879, pag. 331) gives the fluid extract of belladonna in small doses, every two hours, until the face is flushed, or vision disturbed. This impression is to be maintained, gradually diminishing the dose, for two or three days. Frrentzel (*Berl. Klin. Woch.*, March 27, 1876) reports the good effect of atropine in doses of $\frac{1}{100}$ gr. in a severe case of urticaria.

The salicylate of sodium has cured some cases of urticaria, being best administered in grain doses, repeated every hour, until a physiological effect is produced. The literature of this drug, however, shows that large doses have more frequently provoked the eruption. My friend, Prof. A. A. Smith, tells me that he has found this drug to be a valuable remedy in the treatment of urticaria, especially in its acute form, whether dependent upon a rheumatic diathesis or not. He gives fifteen grains in Vichy water, three times a day, or two grains every hour or half-hour, according to the severity of the attack.

Arsenic is a remedy recommended by some writers, but regarded as

of little or no value by others. Morris says: "Chronic urticaria, when unattended by an intestinal irritation, is greatly relieved and often cured by a course of arsenic." The drug has also been found of value by Wilson, Milton, and Hardy. Tilbury Fox, on the contrary, derived little benefit from its use, while Hebra proclaimed it to be worthless.

Strychnia has been recommended by Guibout in urticaria (*Gaz. des Hôp.*, LII., 1879). Duchesne-Duparc (*Traité des Dermatoses*) speaks in highest praise of the internal administration of a fresh tincture of aconite. Bromide of potassium and other sedatives are sometimes curative, according to McCall Anderson, a view which is indorsed by Duhring. Dessau (*N. Y. Med. Jour.*, Dec., 1875) reported two cases of chronic urticaria in children cured by drop doses of balsam of copaiba after much other treatment had failed. I have resorted to this remedy in vain, and know of others who have tested it with a like result. Heitzmann (*Trans. Am. Derm. Assn.*, 1882) reported a case of chronic urticaria completely cured by a few half-drachm doses of the fluid extract of ergot, a drug which has also been recommended by Morrow. Martin (*Bull. de Thér.*, May, 1850) has reported two cases of men who were attacked by urticaria after eating mussels, and relieved of the intense pruritus after taking a spoonful of the spirit of balm. He tested his remedy in another case of severe urticaria, and the result was favorable beyond expectation. Finally, Kelly (*Lancet*, Sept. 18, 1880) relates a case of nettle-rash which was quickly relieved by a wineglass of nettle tea taken several times daily—a capital illustration of the old idea that "the hair of the dog will cure the bite."

From the employment of such a variety of remedies it is quite evident that at the present time our treatment of urticaria is largely empirical and highly unsatisfactory. Most of the drugs which upon unimpeachable authority have effected a cure have failed signally to manifest their alleged therapeutic power in other hands, and perhaps upon second trial by the same hands. Their apparent value has undoubtedly been based partly upon careless observations, and partly upon the fact that the eruption often disappears suddenly without any treatment whatever, the unknown cause having ceased to exist.

The successful treatment of urticaria must depend, as has been already remarked, upon a knowledge of its etiology, and a diligent study of the varying causes of this disease will prove far more conducive to its cure than any amount of blind experimentation with remedies.

KELOID FOLLOWING PSORIASIS.

BY

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THE following brief notes of an attack of keloid following after psoriasis may not be uninteresting. I believe the case to be unique, and have not as yet come across the record of any similar examples.

J. McGarel, aged 28, son of a small farmer, well made, muscular, dark hair and eyes, swarthy complexion, first came under my notice six years ago for an attack of psoriasis. The disease commenced as what he called "ring-worm" over sternum. No other symptoms of the disease for three months. At that time he left for England and began employment in an iron foundry, which, as he says, was "very hot." The eruption then came out on arms, legs, forehead, and obliging him to discontinue work and return home; he subsequently was admitted into the Belfast Skin Hospital, in which he remained for three weeks, and afterwards was an out patient for a like period; the treatment adopted being with chrysophanic acid, and which at that time completely removed the eruption. I lost sight of him till four months ago, when he again applied for admission, with an extensive eruption of psoriasis, the arms, chest, thighs, etc., being thickly covered with silvery scales. Duration of this attack on admission six months. He was ordered Fowler's solution, warm baths with black soap, and Hebra's tincture to be firmly rubbed into the patches, whilst to the extensive eruption on anterior surface of the chest, I used what I have often found beneficial and a rapid way (by one application) of getting rid of the eruption, viz., liniment of iodine, painting a small patch each day; recently he drew my attention to the color of all the places where the eruption had existed, and particularly to those parts on fore-arms where no iodine was applied, and which from pigment coloring are absolutely black, whilst over sternum and epigastric region several keloid tumors have appeared, both on the parts to which the iodine was applied, and also on places, as the epigastric region and sides of the abdomen, where no paint was used. At first I thought these little growths must be due to the powerful action of the liniment of iodine, but since my attention has been especially directed to the subject, I find that *not* to be the case. The largest keloid is in the middle of sternum, about a quarter of an inch long, elevated above level of skin, and is beginning to exhibit the features peculiar to this new-formation; the others vary in size, the smallest being like particles of shot, all occurring around the margins of the patches where the psoriasis has been. I counted to-day nine growths. He is well under the influence of Fowler's solution. Can this have anything to do with the present attack? His family history is good and never had syphilis.

THE TREATMENT OF PRURITIS URETHRÆ DURING GONORRHOEA.

BY

WM. L. AXFORD, M.D.

Chicago, Ill.

DURING the third stage of gonorrhœa a very unpleasant and often distressing symptom that sometimes arises is, the occurrence of a most intense itching along the course of the urethra—a condition not common or not often distressing enough to attract much attention from writers.

In the case of the patient which illustrated most strikingly this complication, in each of three successive gonorrhœas the itching had been so intense as to be almost unendurable, a little relief being obtained by kneading such portions of the urethra as could be brought into position against the arch of the pubes. Various injections were tried in vain, astringents seeming to aggravate the pruritus, others giving but a few minutes' relief.

Finally it was found that by moderately distending the urethra with a cold steel sound (No. 16 Am. scale in this case) the trouble was instantly and completely relieved, but would return again in from twelve to twenty-four hours, the distress being such that the patient would run into the office and ask that the sound be passed immediately.

If the urine were passed soon after the withdrawal of the sound, small yellowish bodies were seen floating about, which under the microscope proved to be masses of pus corpuscles. These were found independent of injections, since medication of all kinds had been discontinued.

It was soon found that this method of treatment had its disadvantages; although it relieved the pruritus, the frequent passage of the sound so early in the course of the disease aggravated the periurethral effusion and in one instance chordee returned, making it questionable if anything had been gained. Afterwards the warm sound and the flexible catheter were found equally efficient and it began to be evident that *distention* of the urethra was the important factor in the problem.

Finally the trouble arising from the frequent passage of instruments was eliminated in the following way: the patient was directed to hold the end of the penis firmly between the thumb and index finger in such a way that no urine could escape, then to make an effort to pass his urine, in this way thoroughly distending the urethra and keeping it distended for one or two minutes, the sensations of the patient to be the guide as to the amount of force to be used. This measure has proved entirely successful, the period of relief is as long as that obtained by the sound, the relief is as complete, and no unpleasant consequences have followed.

Society Transactions.

NEW YORK DERMATOLOGICAL SOCIETY.

134TH REGULAR MEETING, FEB. 27, 1883.

DR. E. B. BRONSON, *President, in the Chair.*

PRESENTATION OF CASES.

DR. TAYLOR exhibited a case of

SECOND INFECTION WITH SYPHILIS.

He stated that this was the third case of the kind that he had seen, and read extracts from an article on the subject which he had published in 1877. The patient, a man about thirty years of age, contracted his first chancre in 1874, his second in December, 1881. About two months after he contracted his first chancre, large red elevated blotches appeared all over his face. In both attacks he had a roseola, followed by a papular eruption, crusts on the scalp and alopecia, and also iritis, both times in the right eye, resulting in adhesions between the iris and lens. During the first attack he was treated by the vigorous use of mercury for five months, which put an end to all his symptoms of syphilis. He has now a few mucous patches in the throat, but had none during the first attack, as far as can be learned.

DR. OTIS said that he had been much interested in the recital of the history of this, as it seemed to him, unquestionable case of second infection with syphilis; such clear histories, being, as a rule, very difficult to get. The possibility of a re-infection with syphilis was, he believed, accepted by all authorities, some regarding it as frequent, an opinion which he himself shared. He had never seen a case that was well made out, but had had a number of cases in which a previous attack was well described, and which had been treated as syphilis.

DR. PIFFARD stated that he had seen only one satisfactory case of this kind. Eight or nine years ago, he had under his care a gentleman affected with extensive leukoplakia of the mouth. The patient said that twelve years before he had been treated by Ricord, in Paris, for syphilis, and he (the patient) believed the leukoplakia to be of a syphilitic nature. While the patient was under his (P.'s) care, he removed an indurated nodule from one commissure of the lips, and found it to be a commencing epithelioma. Some time afterward he treated the patient for an attack of gonorrhoea, and two years later he again presented himself with a typical indurated chancre on the penis, which in due time was followed by a roseola. The leukoplakia remained in about the same condition, treatment having had no effect upon it. He regarded this case as about as well made out as any could be, except one in which both attacks of syphilis have been treated by the same observer.

DR. STURGIS thought there could be no doubt of the occurrence of a second infection with syphilis, but believed that it was much less frequent than is generally stated. In this case the history is so distinct as to be conclusive. He had himself seen one case in which he treated the patient during both attacks. An interval of five years elapsed between them. In both the patient had macular, papular, and iritic lesions. He confessed himself unable to form a positive opinion as to whether, in such cases, the second attack is more or less severe than the first. In his case osteocopic pains were much worse in the second than in the first attack.

DR. SHERWELL said that he believed a second attack might occur, but thought it extremely rare. He had had one case which he held to be of this nature. The patient had acquired syphilis two years before he saw him. When he saw him

he presented what he (S.) regarded as a true chancre, but finally concluded to be a chancroid modified by a previous syphilis, his observations having taught him that all lesions in such subjects, even when of traumatic origin, are apt to present more or less induration of their bases and margins. This patient had no roseola in his (supposed) second attack, but did later present a lichenoid and pustular eruption, and now suffers from osteocopic pains.

DR. OTIS said that the point concerning induration of non-specific and traumatic lesions in syphilitic subjects brought out by Dr. Sherwell was new to him.

DR. SHERWELL said that he had made the statement as the result of his own observations alone. He had seen a number of cases which illustrated its truth, and had at present a case of marked traumatic ulceration under his care, with pronounced induration around the edges of the lesions.

DR. MORROW said that abundant opportunities to observe such induration must have been afforded by the results of the numerous experiments in syphilization, yet he was unable to call to mind the fact that any one had made such an observation, the lesions produced having always remained soft.

DR. PIFFARD had seen many of the cases in which Dr. Boeck had practised syphilization while in this country, but had never seen any induration, the sores always remaining soft.

DR. STURGIS expressed the thought that perhaps Dr. Sherwell had not drawn the distinction between induration and infiltration with sufficient positiveness in his observation, and confirmed the statement of Dr. Piffard concerning the results of syphilization.

DR. TAYLOR, referring to the case which he had exhibited, said there could be no doubt whatever of the reliability of the history, he having carefully eliminated all possible sources of error before accepting it as a case of second infection. When the patient came to him, he presented a well-marked corona veneris, and at the same time a macular syphilide. Of the existence of the latter the patient was, however, ignorant, so we are justified in believing that he had a similar eruption during the first attack, and failed to notice it. A point of interest in the case was the fact that he had had a very energetic course of mercurial treatment during the first attack for a period of five months, and afterwards no further treatment and no lesions, and yet acquired a second chancre. This proves the curability of syphilis by mercury. Another important question illustrated by the case concerned the comparative severity or mildness of the second attack in contrast with the first. In two other similar cases that he had had (in one of which he treated the patient during both attacks), the second was very much more severe than the first. In the present case, also, the patient's nutrition is bad, but not sufficiently so to aid us much in forming an opinion on the subject. Reference was also made to cases reported by Pellizzari, in which a husband and wife had both suffered from two attacks of syphilis.

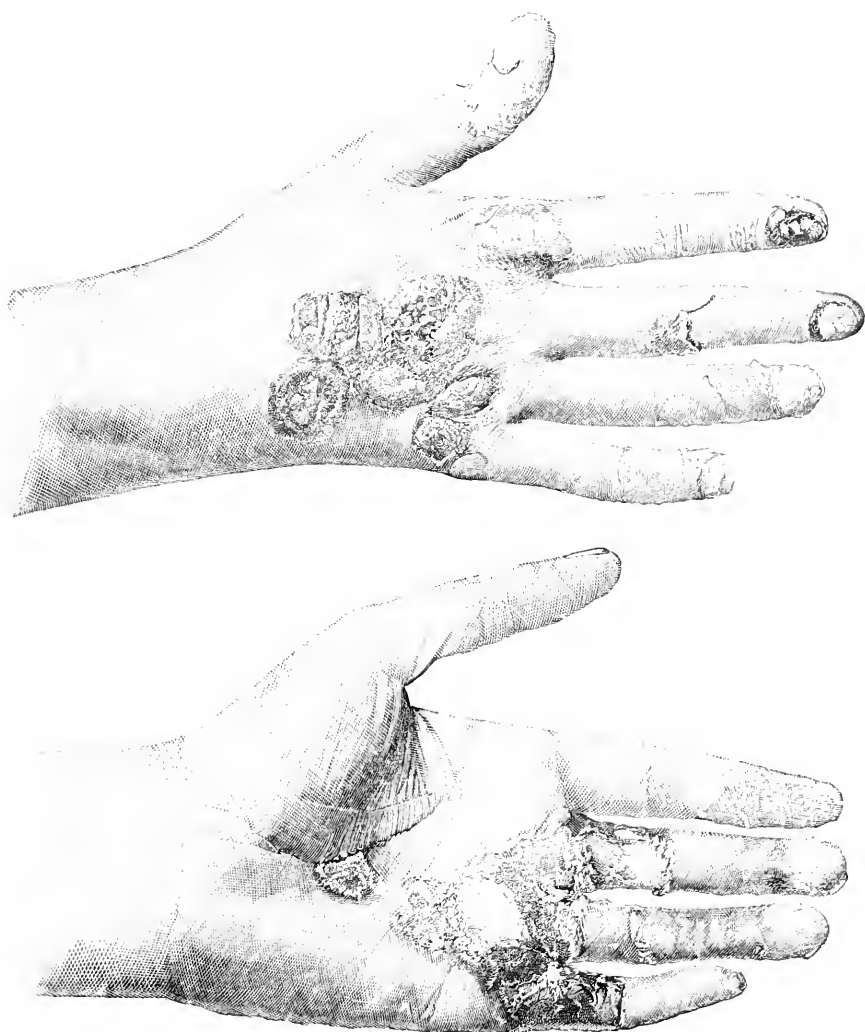
DR. BRONSON spoke of a case recently reported by Hans Hebra in the *Monatshefte für praktische Dermatologie*, in which a man who had been treated for syphilis by the elder Hebra came under the observation of the younger for treatment for an indurated chancre.

DR. MORROW exhibited a

A CASE OF GENERAL PSORIASIS AFFECTING THE PALMS.

The patient, a woman twenty-four years old, had a general scaly eruption (probably psoriasis) at the age of ten years, from which she entirely recovered. Four years ago she had trouble with the right thumb nail, which became thickened and scaly. She married two years ago, and has now one child, seven months old and in good health. Her husband is also healthy, with the exception of chronic rheumatism. Two months after the birth of the child, the mother's nails again began to trouble her, gradually exfoliating, and an eruption appeared on various parts of her body, principally the hands, arms, and legs, with scattered patches on the trunk. When he (M.) first saw her, a few weeks ago, the nail-bed of all the fingers was occupied by a thick, heaped up amorphous substance, friable and irregularly furrowed, and presenting a very peculiar grayish appear-

ance, as if roughly covered with mortar. There now seems to be some attempt at organization of this substance it being reddish in color and more compact, and giving some suggestion of a normal nail, which it did not before. Absolutely no history of syphilis can be obtained, except the former presence of scabs on the scalp and alopecia. She has had the present eruption five months. On



the legs, arms, and in a few spots on the right breast, abdomen, and back, the lesions are of a circular form, and covered with a thin layer of scales, the removal of which shows a glazed, dry, smooth, intensely red surface. Around each patch (the majority of which are about the size of a trade dollar) is a circular, narrow red ring, which is comparatively free from scales, and has a sharply

marked border, in strong contrast with the surrounding healthy skin. On the palms of the hands and the fingers (both aspects), the patches have become confluent, the skin being intensely red, thickened, scaly, and somewhat infiltrated. The patient has no nails (except rudimentary ones) on the hands. There is a large patch on the right palm extending from the root of index to little finger, and also a few small isolated patches on the palms, similar in character to those on the arms. The feet have not been affected by the diseased process.

DR. FOX thought that both psoriasis and syphilis were present in the case, but said that he regarded the eruption as one of psoriasis, and not as a squamous syphilide.

DR. TAYLOR analyzed the history of the patient, and showed how it pointed to psoriasis. The facts that the disease first showed itself during lactation, the absence of enlarged glands and of a history of syphilis, and the dry red, not copper-colored, flat, inflammatory, non-indurated surface found after removing the dry scales, all go to warrant one in making a diagnosis of psoriasis. The objective features presented by the nails are also conclusive evidence of its non-specific nature. In syphilitic nail-lesions, the fingers are club-shaped, whereas here they are thin and tapering. If this case were one of syphilis, there would also be thickening of the periosteum and ulceration in the furrows around the nails.

DR. OTIS was also of the opinion that it was a case of psoriasis. He had frequently seen psoriasis and syphilis in combination, and recalled one case in particular in which the syphilitic lesions were removed by mercurial treatment, leaving those of psoriasis intact, and a similar case, with a similar result, where an acute general eczema developed upon a syphilide. He had never seen psoriasis or any other skin disease modified by syphilis.

DR. SHERWELL said that he did not regard the palmar lesions as psoriatic in nature, and expressed his firm conviction that psoriasis never shows itself on the palms except in syphilitic subjects. He believed this to be a case of superimposed diathesis, one of psoriasis occurring in a syphilitic subject.

DR. BROXSON said that the appearance of the patches was misleading, the peripheral rings devoid of scales resembling the little walls that are usually found around syphilitic lesions. He thought these rings simply the most recent outcroppings of the disease which had not yet become scaly. But they are not indurated, as they would be if syphilitic, and there is absolutely no sign of syphilis on the palms.

DR. MORROW said that four weeks ago he was unable to decide whether or not the eruption on the fingers was psoriasis, because it presented none of the usual features of that disease. He stated that he had since modified his opinion of the case, and now believed it a psoriasis, the unusual development of which was determined by lactation.

DR. STURGS exhibited a case of

ENLARGED SCROTUM AND PREPUCE.

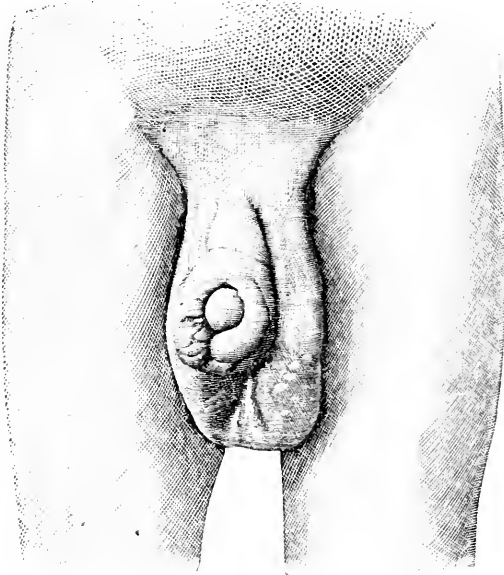
The patient, thirty-three years old, had acquired syphilis four years before, and had also had chancreoids. The prepuce had been slit up at some previous time, and the glans penis is now exposed. In the preputial sac, underneath it, is a cluster of flat, red sessile warts. The skin of the penis and scrotum is enormously thickened and somewhat oedematous, the whole forming a pendulous reddish-colored mass as large as a child's head. There are no abnormal sensations in the parts. The disease has lasted four years. Suggestions as to treatment were asked for.

DR. PIFFARD thought it a case of hypertrophy of the scrotum and penis due to a mechanical closure of the lymphatics which drain the parts, by their being blocked up by inflammation due to the chancreous or chancroidal virus. He did not regard it as a case of elephantiasis arabum.

DR. TAYLOR alluded to a case of well-marked elephantiasis of the penis, which

came under his observation on the person of a young Jew. The disease began in the cicatricial ring left after circumcision, and finally involved the whole organ. It developed from a balanitis. He believed that it was identical with the disease known as "lymph scrotum."

DR. PIFFARD said that "lymph scrotum" was an entirely different affection from the disease under consideration, and in it the parts are often covered with small nodules, from which the lymph exudes on puncture. That disease is known to be caused by the *Filaria sanguinis*, which are believed to gain entrance into



the body by drinking water containing the ova of a certain kind of mosquitoes. He thought excision of at least a portion of the mass should be done in this case.

DR. BRONSON recommended a trial of multiple punctures before resorting to other means.

DR. SHERWELL advised mercurial inunctions.

DR. STURGIS said that he was, of course, aware that the disease was not a true, but only a pseudo-elephantiasis. He believed that it was a hyperplasia of the parts, induced by blocking up by the lymphatics. The mass is slowly increasing in size, and will doubtless have attained excessive dimensions ten years hence.

DR. FOX exhibited a case of

MACULAR LEPROSY.

The patient, J. H., was a man thirty-four years old, born in the Sandwich Islands, of New England parents. About seven years ago, a spot of the size of a silver dollar appeared on the left thigh, became slightly anæsthetic, and gradually extended up the thigh. A year and a half ago, the first and the second fingers of the right hand became numb and swollen. Six months ago, this numbness became more marked, a large blister formed on the second finger, and the third and little fingers of the left hand became affected. About this time the nose began to swell, to feel numb, and assume a dull-red hue, and a small spot appeared over the left eyebrow. Soon afterwards a spot appeared upon the lower lumbar region, and contraction of the fingers began. One month ago, a small superficial abscess ap-

peared on ulnar border of left hand, and is still discharging a little. At this time a spot was also discovered on the right foot, and one between the scapulae.

The patient is now in excellent physical condition. The patches are of a peculiar brownish-red hue, and the loss of sensation in the skin is not marked. The hands are slightly crippled from the contraction of the fingers and the numbness. There is no decided enlargement of the ulnar nerves. The patch on the back, which presents the most typical appearance, has a slightly elevated border and a paler centre. The patient has taken large doses of nux vomica and strychnia for a few weeks, and has used inunctions of oleate of mercury on the patches. Dr. Fox stated that he presented the case mainly for the purpose of ascertaining the opinion of the Society as to the contagiousness of the disease, and upon the propriety of a physician allowing a patient afflicted with leprosy in a mild form to remain at a hotel, thereby incurring the blame which the public would unjustly cast upon him, should the fact become known.

DR. PIFFARD alluded to the increasing number of cases of this affection in this country, and expressed his earnest conviction that if such cases chose to remain at large, the responsibility rested with the people and not with the physician. He thought it the duty of the government to establish a lazaretto, in which all lepers who desired to remain in this country, should be compelled to pass their lives. He also thought that such cases should be reported to the Board of Health, which would throw the responsibility of deciding the question raised by Dr. Fox, upon them. As regarded this patient, however, he thought that it would scarcely be necessary, as the disease was so slightly advanced that the man might possibly be cured, and that by the treatment employed by Dr. Fox, which he thought decidedly the best.

DR. STURGIS said the question was a hard one to decide, and that it would be best to leave it to the patient on the whole. If the physician were forced to give an opinion, he thought he should advise such a patient to leave the city.

DR. FOX said that he was glad to have the approval of the Society of the course that he had adopted. In his own opinion, leprosy was contagious in the same manner as syphilis, and probably in about the same degree. The policy of quarantining a leper and allowing syphilitic patients to be at large must be based upon the graver nature of the former disease or upon the unreasonable dread of leprosy which exists among the laity. The risk of infecting other members of the family or friends with whom the patient associates, is no greater in one case than in the other.

DR. STURGIS exhibited a case of

ELEPHANTIASIS OF THE LEG

in the person of a man, sixty-nine years old. The disease extended above the knee. There was an ulcer on the outer side of the leg which had much diminished in size under treatment. Suggestions as to treatment were asked for.

DR. BRONSON could see no reason to regard this as a case of true elephantiasis arabum. Such thickening of the limb might have been caused by chronic diseases of the part, such as ecchyma, varicose veins, etc., producing long-continued irritation in it.

DR. PIFFARD spoke of the confusion attending the ordinary use of the term elephantiasis arabum. The disease usually originated in tropical countries, and, this patient, having spent a year in Buenos Ayres, he thought it probable that he had acquired the disease there. This affection is characterized by the repeated occurrence of febrile attacks, so closely resembling fever and ague that some observers regard it as simply a form of malaria. As regards treatment of the affection, he stated that elastic compression and electrolysis had both been successfully employed, the latter sometimes with very striking benefit. He instanced the writings of Drs. Moncorvo and Silva Araujo (*L'União Medico*, Dec., 1882), showing cases before and after treatment. He had himself used elastic compression in

1873, and published his results in 1876, not knowing, at the time he employed it, that it had previously been used by Vidal, and since then by others in France.

DR. TAYLOR spoke of a case which he regarded as identical in nature with



this. The disease began in a gummatous ulcer on the leg, and extended up to the knee. He thought that, in view of the advanced age of the patient, the best course to pursue would be to make him comfortable, and abstain from active treatment.

Selections.

LECTURE ON THE DIAGNOSIS OF SKIN-DISEASES.

BY DR. E. GUIBOUT.

GENTLEMEN:—We are not dealing with abstract science, speculative, and incapable of useful application; let us remember that medicine is the art of healing, *ars medendi*. In directing your attention, then, to dermatology as forming a kind of summary of all pathology; in showing you that the skin is like a mirror on which the most diverse morbid conditions, the slightest as well as the most serious, are reflected, photographed, as it were, before your eyes; in proving to you that the various cutaneous affections are but so many morbid currents which, taking their rise from all parts of the economy and from its deepest recesses, ascend to the surface, and converge at last upon the skin, I have not aimed at setting before you an attractive picture calculated to excite a purposeless curiosity. No! Mine has been a higher and more serious object. I have sought to make you look upon dermatology as an illuminating agent, the

torchlight of diagnosis, and therefore worthy of being your constant guide and the subject of your earnest study.

What constitutes a correct diagnosis in dermatology? Upon what considerations does it chiefly depend, and what are its difficulties? These are the points to which I invite your attention.

I.

When confronted with a case of cutaneous disease, you must survey it at the very outset, in its largest aspect, overlooking nothing that is important to the patient or to the success of your treatment. Do not suffer yourselves to be engrossed by petty questions of detail, but, when called upon to decide whether your patient is in serious danger, whether his health is deeply affected, endeavor at once to appreciate, to understand, to ascertain his pathological condition, instead of wandering about in a wilderness of minutiae, and amusing yourself by inquiring whether the cutaneous lesions you are looking at began in a vesicle, a papule, or a scale. In short, it is the diagnosis of the malady, the interpretation of its semeiological expression that must engage your first attention—this is the unknown quantity which you are to begin by finding out. Consider that almost the entire range of pathology is involved in your dermatological studies: Idiopathic, parasitical, cachectic, and critical affections; dental, uterine, gastrointestinal, acute and chronic disorders; emotional shocks; periodical pseudo-exanthemata: genuine *exanthematous fevers*; syphilis, scrofula, herpetism, cancer. Try not to forget that dermatology comprehends all these, as was proved to you in our last lecture—and now you see what it is that you have to bear in mind on reaching the bedside of your patient. A sort of chaos, no doubt, but be not afraid; you will find a light which will disperse the confusion—an Ariadne's thread which will direct you through the windings of the labyrinth.

Every cutaneous disease has its own seal, its peculiar aspect, its distinctive and pathognomonic features, which will enable you to recognize and name it, and if the light thereby afforded should not break upon you at once and with sufficient vividness, a reference to the ensuing memoranda will assist in clearing up the case.

Is the disease confined to a part of the body exposed to the action of external irritants, whether due to the patient's occupation or to other causes? It is idiopathic. Is it situated around the abodes of parasites, whose presence may be suspected if not actually demonstrated? It is parasitical. Did it come on after an error in regimen, or as the result of drug-medication, or of partaking of indigestible food, or in the course of a chronic dyspepsia? It is a symptom of visceral disorder, and pertains to the skin in a less degree than to the stomach and bowels.

Are the cutaneous lesions of a reddish-brown or a deep copper color, or like the flesh of a raw ham, and without itching? It is syphilis. Are these same lesions scattered irregularly over the entire surface? It is *recent* syphilis. Are they, on the contrary, collected in groups? It is syphilis of *long standing*, and if ulcerations are present, it is syphilis in the tertiary stage.

Are the lesions permanently fixed upon a single region, on which, during a longer or shorter period, they have been going through all their phases of development, in a torpid and chronic manner, and are they painless and of a bright wine-like red color? It is scrofula.

Are they, on the contrary, pruriginous, intermittent in their manifestations, spread over the entire surface, and disposed symmetrically, *i. e.*, so as to occupy

corresponding portions of the body and limbs in the same way and with the same geometrical configuration? It is ring-worm or herpeticism.

After this manner, gentlemen, you must endeavor, first of all, to ascertain the nature of the disease. This is the great problem to be solved; this is what it chiefly concerns you to become acquainted with, for the sake of your patient, and that you may know what treatment to apply and how to shape your prognosis, both as to the duration and the gravity of the complaint.

But this is not enough; you must bestow a name upon the disease you are investigating. This disease has originated, we will suppose, in the *occupation* of the individual or it is *herpetic*, or it is *syphilitic*. You have classed it under some one of these heads, according to the arrangement, the color, and the general appearance of the lesions—but what will you call these lesions? This is what must now be determined. In order to do so, you have two questions to settle: 1st. What is the *species* of the eruption? 2d. What is its *genus*?

What is the species? That is, what is the primary anatomical lesion which constitutes the affection? Is it a vesicle? Is it a pustule? Is it a scale? Is it a simple discoloration?

What is the genus? That is, under what variety is this primary lesion to be placed? If it is vesicular, what is the character of the vesicles? Are they small, granular, acuminate, ephemeral, and confluent, over extensive erythematous surfaces? If so, they belong to the genus *eczema*. Are the vesicles, on the other hand, arranged in small, isolated groups? Are they large, flattened, persistent in duration, and replaced, each one, by a blackish crust? In this case, you will assign them to the genus *herpes*.

But it is not sufficient to decide upon the nature of the malady and the generic name of the lesions which are its outward expression. You must also ascertain to what period of development these lesions have attained. Thus, for example, supposing that you have a case of eczema to deal with, and that the disease is in its first, second, or third stage, your treatment should be local and purely antiphlogistic, and you must be careful to avoid any definite prediction as to the probable duration of the complaint. But if it has reached its fourth period, that of scaly eruption and desiccation, you may safely announce that it is rapidly declining, and your antiphlogistic measures will be no longer applicable.

You will readily understand that this necessity of ascertaining the period of the eruption—a necessity imposed by the requirements of prognosis and treatment—involves, both in every case and as a general rule, an equal necessity of determining the character and form of the cutaneous affections. Are these of an acute nature, running a rapid course, moist in their secretions and inflammatory in their type, like eczema, herpes, impetigo, periodical ecthyma: or are they slow, torpid in development, without a sign of inflammation, and dry in their secretions, like psoriasis, or pityriasis alba; or else without any secretion at all, like prurigo and chronic lichen? The determination of the inflammatory or non-inflammatory, of the acute or chronic character of cutaneous affections is an indispensable point in their diagnosis, since their treatment, both local and constitutional, will differ essentially in the two cases.

The diagnosis, then, of cutaneous diseases, should be made to turn upon five perfectly distinct points, which it is absolutely necessary that you should ascertain with the utmost precision, in order to obtain a clear and comprehensive idea of these diseases, and be enabled to oppose to them a methodic and rational plan of treatment. The five points are: 1st, the nature; 2d, the species; 3d, the

genus; 4th, the period of evolution; 5th, the form, acute or chronic, of the maladies in question. In this way is their diagnosis to be conceived and formulated.

II.—OF THE DIFFICULTIES IN DIAGNOSTICATING SKIN-DISEASES.

Is there any difficulty in forming a diagnosis according to the rules we have just laid down? At the first glance it would seem that there is none; nothing apparently can be easier than to determine the different points involved in this inquiry; in fact, everything relating to cutaneous diseases seems to lie upon the surface and to be displayed before our eyes; not only can we see the lesions, but we can come into direct contact with them, and consequently can form the clearest and most complete conception of their character, their anatomical constitution, their extent, their importance, their color, and their individual and pathognomonic peculiarities. Such is the first idea which occurs to us; unfortunately, this idea is not always correct; diagnosis in very many cases of this kind is exceedingly difficult, owing to causes which we shall pass rapidly in review, and which may be enumerated as follows:

1. *Tardy examination of patients.*—Our aid is not usually invoked at the commencement of these complaints. As a general thing, we do not see them until they have reached a pretty advanced stage. Now, at this period, time, which alters all things, has effaced or perverted the pathognomonic characteristics of the eruptions; it has obliterated every trace of their primitive anatomical constitution; we shall endeavor in vain to discover them: we can discern only secondary lesions, possessing no well-marked or distinctive features; and yet it is with the sole aid of these lesions, thus disfigured and corrupted, that we must undertake to frame our diagnosis.

2. *Effects of previous treatment.*—When a patient of this class comes to be examined, not only has his complaint been modified by the lapse of time, but the treatment he has already undergone has contributed to deprive it of its most important characters. Thus, we may behold psoriasis stripped of its white and nacreous scales; rupia divested of its thickened, blackish, moist, and stratified incrustations; eczema without its yellowish-white crusts.

You will frequently, gentlemen, meet with patients who have been subjected to irrational modes of treatment, which have irritated where they should have soothed, and which, consequently, have resulted in lighting up a latent inflammation. These procedures completely alter the characteristic aspect of the cutaneous lesions; they aggravate them, it may be, by giving rise to new eruptions, whose more decided development sometimes entirely covers over the original lesions, which are then so disguised as to be no longer recognizable. In these cases it is necessary to begin by removing the effects of such unfortunate treatment, and not until this is accomplished is it possible to form an idea of the genuine malady.

3. *The simultaneous occurrence of several distinct diseases on the same region.*—You will often observe an inflammation of the skin to be manifested by different species of eruptions which are seated side by side upon the same region. Thus the papules of prurigo may coexist with the pustules of eczema. The more abundant crop, in such a case, will completely hide the other eruption, so as to prevent you from remarking the existence of the latter, which yet, as the older and more important phenomenon, it is especially desirable that you should recognize. In this way you will find chancres, mucous tubercles, pustules, the

cups of favus, which have been shielded from your view by the thickened crusts of herpes, of eczema, or of impetigo.

4. *The constitution and situation of diseases.*—Plants have their territorial preferences; it is the congenial nature of the soil from which it springs that confers upon each of them its own measure of strength and growing energy, or of beauty and grace. Let it be transferred from this to ground that is unsuited to it, and you will scarcely be able to recognize it, so great will be the change. It is the same with the morbid proliferations which constitute the cutaneous diseases; they, too, have soils especially adapted to them; some must be planted in the dry ground of a thick integument: others prefer a skin that is delicate and moist; psoriasis, for example, with its beautiful white, thick, and silvery epidemic scales, seeks for its development those regions of the body where the skin is driest and the outer cuticle most dense; it is there, on the back and along the outside of the limbs especially, that the disease will be found in its fullest and most characteristic efflorescence. But look at it now, as it appears on a part where the integument is delicate and moist, as on the scrotum, the penis, or the entire genito-crural tract—here it is as if gone astray; here the elements are lacking for its normal growth: its scales are mere dry, discolored films, which peel off spontaneously. Psoriasis it is still, but a bastard psoriasis, which only a practised eye is able to identify.

If the bodily region which is the seat of a cutaneous malady may make its diagnosis difficult, so also may the peculiar constitution of the patient. Take the herpetic eruptions, for example. In the case of a lymphatic or a scrofulous individual, they will cause less itching, will be more humid, and their secretions more abundant. On the other hand, a dry, nervous constitution will exhibit them in a drier and more painful form; for this is the soil most favorable to prurigo in its severest manifestations. Again, look at syphilis in a scrofulous subject; it has parted with its color, with its characteristic impress; it is entirely changed; its lesions present a hybrid aspect, half syphilitic, half scrofulous; it is the venereal disease no longer, but a compound of two diatheses; a nondescript for which dermatology has no name, but which M. Ricord has denominated a *scrofulate of syphilis*. Thus it is that the seat of the disease and the constitution of the patient may alike contribute to embarrass the diagnosis.

5. *The abnormal forms assumed by certain skin-complaints.*—The most common cutaneous affections sometimes appear under unusual or deceptive shapes, which render them unrecognizable. Thus the varieties of psoriasis known as *gyrata*, *circinnata*, and *guttata*, in which no scales are produced, bear so close a resemblance to serpiginous and papular syphilis that their diagnosis is frequently impossible. Horny vegetating syphilides are no less difficult of distinction. *Centrifugal* palmar eczema shows a misleading likeness to the scaly, serpiginous syphilide. *Orbicular* or *radiating* eczema is so fantastic in its development that one knows not what to call it.

Enough, gentlemen, has now been said to convince you that the diagnosis of cutaneous diseases is often beset with serious difficulties. Attentive observation is required that you may become familiar with these difficulties, and thus avoid the commission of errors which would be prejudicial alike to your own reputation and the welfare of your patients.—*L'Union Médicale*, July 23, 1882.

OBSERVATIONS ON THE MICROBES OF BLENNORRHAGIA.

THIS paper details the results of a series of elaborate microscopic investigations into the nature of the blennorrhagic virus, and is believed by its author to

embody "the expression of a constant law." The "gonococci," previously described by Neisser and others, he found to be uniformly present, but he decidedly rejects the opinion that they constitute in an exclusive sense the microbes of blennorrhagia, since he has discovered organisms precisely similar in cases of acute and chronic ulceration of the bowels and lungs, and also of ulcerative stomatitis. In fact, he regards these gonococci (to use his own expression) as a sort of pathological "sappers and miners." But Dr. Eklund has also discovered in pus and the superficial exudations of the inflamed urethral mucous membrane an entirely new species of parasite, which he denominates *ediphyton dictyodes*. This, like all similar microbes, is propagated by the rapid and simultaneous extension of a vast network of mycelium-filaments into the glands, the lacunæ, and the ultimate cellules of the affected structure. Yet it is only exceptionally that this growth gives rise to a constitutional infection such as is manifested in diphtheria. The explanation of this fact is as follows: In the first place, the dense fibrous investment of the urethral mucous membrane opposes an insurmountable obstacle to the advance of the parasite in this direction: and secondly, the power of resistance is generally at its height in the human system at the period when blennorrhagia is most apt to be contracted. Nevertheless, in some cases of pulmonary blennorrhœa (chronic pneumonia with pneumorrhagia and secondary phthisis) consecutive on blennorrhagia, the presence of both gonococci and the *ediphyton dictyodes* in the pus-cells and sputa has been fully established. Acute miasmatic pneumonia, as it occurs in northern latitudes, affords a similar example.

The *ediphyton dictyodes* presents itself under two distinct forms, one of which originates in the vegetable kingdom, while the other is developed from animal matter in a state of putrefaction. Long and glassy filaments of mycelium are well-known to exist in the urine of scarlatina patients and of those recovering from the disease, and if such urine be left standing in summer, a network of these filaments, resembling that which characterizes the second variety of *ediphyton dictyodes*, will begin to form. It is a matter of daily experience that, in consequence of the urine coming in contact with the vulva, the mycelium-filaments may be developed in the vaginas of female patients when convalescent from scarlatina, and thereby give rise to blennorrhagia—in which case both varieties of the microbe will be present.

In all of the author's examinations of pus from soft chancres, and of the superficial layers of the same, he has found an organism identical in all respects with the gonococcus of Neisser, and also the woven filaments of *ediphyton dictyodes* in both its forms, but especially that derived from animal putrefaction. Hence he believes the virus of soft chancres and that of blennorrhagia to be identical. The difference between the two diseases is caused simply by the parasites being developed in the one case on the surface of the mucous membrane, and in the other within the substance of the derma. A previous lesion of the cutaneous surface is also requisite for the production of the soft chancre, while the gonococcus and the *ediphyton dictyodes* possess a degree of vital force which enables them to attack the uninjured mucous membrane of the urethra.

Women are often affected with a purulent cervicitis presenting all the characters of a blennorrhagia, and microscopic examination of the yellow pus, which in such cases collects abundantly in the posterior cul-de-sac, will disclose a dense mass of vibriones resembling the organisms above described. These vibriones are the cause of perimetritis and septic peritonitis of a very dangerous character.

Microscopic tests were also applied by Dr. E. to several of the curative agents which are usually employed against blennorrhagia. The saturated solution of boric acid, which is in common use as an injection, was found not to have the slightest effect either on the gonococcus or the ediphyton dictyodes. A two-per-cent solution of nitrate of silver appeared to be equally inert; and even after a copious addition of a super-saturated solution of the bichloride of mercury (1 : 10) the gonococci continued in lively motion for several hours. A drop of eucalyptus glob. applied directly to the parasites reduced them to quietude, but it is doubtful whether it deprived them of the power of propagation. As the author possesses some exquisite preparations of the E. dictyodes preserved in solutions of iodoform, of eucalyptus essence, and of bichloride of mercury, he has no confidence in the ability of any of these substances to prevent the growth of the parasite.

The means recommended for the treatment of blennorrhagia are cold sitz-baths (after the subsidence of the inflammatory stage), together with injections of carbolic acid (1 : 60), of chloral-hydrate (2 : 300), and the internal administration of copaiba and cubebs. Daily examinations of the urine of convalescent patients showed that the gonococcus was the first to disappear. The E. dictyodes was much more difficult to eradicate, and only yielded to a persevering use of the cold sitz-baths.

The best prophylactics against blennorrhagia are strict attention to local cleanliness on the part of the female, and the introduction of bougies medicated with carbolic acid into the male urethra.—EKLUND, *Ann. de Derm. et de Syph.*, Oct. 23, 1882.

THE CUTANEOUS MANIFESTATIONS OF MALARIA—MALARIAL HERPES.

THE authors begin by reminding us that the two great constitutional disorders—scrofula and arthritism—certain virulent maladies, of a subacute or a chronic type, viz., glanders and syphilis, and the contagious eruptive fevers—variola, measles, scarlatina, etc.—as well as several diseases of parasitical origin, are frequently, if not uniformly, accompanied by cutaneous manifestations peculiar to each; and, moreover, that these latter are in most cases so distinctly marked as to constitute, by themselves, a sufficient means of diagnosing the general affection in which they directly originate, and of which they are the outward and visible expressions.

Now, cutaneous eruptions, in very diversified forms, are also of frequent occurrence in the course of intermittent fever, both at the time of the paroxysm and during the apyrexia. It might therefore be asked whether such eruptions ought not to be placed in a class by themselves, like those first spoken of, and be christened, perhaps, "paludides," just as we speak of "syphilides." "scrofulides," "arthritides," meaning thereby the symptomatic eruptions of syphilis, scrofula, or rheumatism.

In reply to this, it is pointed out that before these new titles can be admitted into our dermatological scheme, two conditions must be fulfilled. First, the eruptions in question must be proved to be direct results of malaria. This, with respect to some of them, is undeniably the case. Secondly, they must be distinguished by such unequivocal signs of genuine specificity as shall make it impossible to mistake them for anything else than malarial products. This, however, the most important of the required characteristics, is not to be met

with in the cases we are considering. The eruptions proceeding from malaria differ in no respect from those due to other causes, and are connected with the former influence only by their occurrence during the febrile paroxysm, or by the unusual course which they occasionally pursue.

While, then, we may admit the existence of malarial eruptions, and, if we please, may call them "paludides," we cannot, under this title, allow them to rank as of equal importance with "scrofulides" or "syphilides." Indeed, any attempt to unite the multiform and incongruous eruptions of malaria into a new and well-defined class would certainly carry us too far.

The subject in its most general aspect being thus disposed of, the rest of the paper is devoted to the consideration of malarial herpes. The conclusions arrived at are summarized as follows:

1. Herpes is one of the most frequent manifestations of malarial infection.
2. It may precede the paroxysms of intermittent fever, may be developed during either of the three stages of the paroxysm, or may occur after the sweating stage. It may also make its appearance when the disease has been suppressed by quinine. There is therefore no causal relation between the eruption and the fever, despite their frequent co-existence.
3. Malarial herpes exhibits no peculiar characteristics. Its favorite localities are the face, the circumference of the lips and nostrils, the eyelids, the cornea, and, in general, the parts most abundantly supplied with nerves. The eruption is usually discrete, but, in some epidemics, has become remarkably confluent.
4. The presence of black crusts, and especially of black vesicles, is apparently connected with grave and pernicious forms of malarial fevers.
5. In exceptional cases, malarial herpes assumes the shape of zona.
6. The eruption, as it most commonly occurs, may be preceded and accompanied by vaso-motor and sensory disturbances in the affected integument. Its ordinary localities, its concomitant symptoms, and its occasional appearance during the apyrexia or when the fever has been suppressed, all warrant us in attributing its origin to a nervous lesion—perhaps a congestion of the cutaneous branches, caused by the malarial poison having become seated on the latter.—VERNEUIL and MERKLEN, *Ann. de Derm. et de Syph.*, Nov. 25, 1882.

ALTERATIONS IN THE STRATUM GRANULOSUM, AND ITS DISAPPEARANCE IN CERTAIN CUTANEOUS DISEASES.

THE investigations of M. Ranvier, in the year 1879, revealed the presence, in the cells of the stratum granulosum, of a peculiar fluid which he denominated eleidine. "The formation of eleidine in the stratum granulosum (says M. Ranvier), its diffusion into the stratum lucidum, and its disappearance in the horny layer, indicates that this substance performs an important part in the process of epidermic keratinization." This action, in its physiological aspects, is described as follows:

Wherever the cuticle becomes thickened—as, for instance on the palms of the hands and soles of the feet—sections of the same will show us the eleidine existing in large drops from the stratum granulosum and spreading into the stratum lucidum, and even beyond it: in fact, the stratum granulosum itself is made up of several layers of large cells inclosing abundant granules of eleidine. On the other hand, in situations where the epidermis is delicate (as at the bends of the elbows and knees), the stratum granulosum consists of only one or two layers of lozenge-shaped cells containing but a small amount of eleidine, which is not diffused into

the stratum lucidum. Again, where the common integument merges into the mucous membrane, as at the vermilion borders of the lips, both the stratum granulosum and the stratum lucidum disappear, and the cells of the superficial layers preserve their nuclei.

These statements premised, the author's leading positions will be readily understood from the following summary, and accompanying remarks, with which his paper concludes:

1. The normal process of epidermic keratinization is characterized by the presence of eleidine in the cells of the stratum granulosum, together with the disappearance of the nuclei from the horny layer.

2. In those pathological conditions which involve "*lésions formatrices*" of the epidermis, tending to hypertrophy of the horny layer, we observe an exaggeration of the above-described phenomena—that is, there is a thickening of the stratum granulosum, together with an abnormally abundant secretion of eleidine.

3. When the horny layer of the epidermis is altered so as to produce on its surface a scale or a vesicle, the stratum granulosum disappears from the seat of the eruption, while the cell-nuclei become visible in the corresponding portion of the horny layer.

In this way, we are enabled to distinguish, by well-marked histological signs, between formative inflammations of the epidermis and those affections which issue in squamous or vesicular degeneration. Thus, moreover, we observe that in the eruption of variola the two processes referred to—that of epidermic development and that of colloid degeneration—occur simultaneously in the same case. So that it is no less true of the skin than of other tissues, that inflammation, properly so called, and even tumors, possess certain characteristics in common, which show that their development is regulated by the same general laws.—SUCHARD, *Arch. des Physiol. Normal. and Path.*, 1882, 2d Ser., x., 305.

A CASE OF SUDDEN CHANGE IN THE COLOR OF THE HAIR CAUSED BY VIOLENT NEURALGIA OF THE SCALP.

KAPOSI, in his treatise on cutaneous diseases, maintains, in the most explicit manner, that the generally received accounts of persons whose hair has changed color suddenly, under the influence of fear or other strong emotions, must be rejected *in toto*, since such changes are physiologically impossible. This opinion is controverted by Dr. Raymond, in the *Rev. de Méd.*, No. 9., for September 10. After citing in opposition to it the authority of Charcot, he adduces the following case in confirmation of his views:

Madame D., aged thirty-eight years, a lively, nervous, and very impressible lady of very fair complexion, which strikingly contrasted with her abundant black hair, was deeply grieved at having to part with her son, who went to finish his education in Germany. Six months later she was again greatly disturbed in mind on learning suddenly that she had lost a considerable amount of money in some stock operations. She now became agitated and restless, lost sleep and appetite, and was finally attacked with severe neuralgic pains in different parts of the body and head. The bad news referred to reached her just as menstruation was setting in, and this function was immediately suspended. The pains continued steadily to increase, in spite of the administration of quinine, aconite, and bromide of potassium, until at last, in the head especially, they became intolerable. Morphine afforded no relief. At two o'clock in the morning of the fifth day, the neuralgic affection reached its climax. At this time, the patient's hair appeared as usual. Seven hours later its color was completely changed. On

the sides and back of the head it was still black, but elsewhere it presented for the most part a fiery red hue, some of the smaller hairs, however, having turned quite white. In some places the white and black hairs were intermingled in almost equal proportions. These appearances were confined to the head, the hairs on the other parts preserving their natural color. The pains in the head remained unabated for a few hours, when they began gradually to diminish, and in four or five days had entirely ceased. In the mean time, most of the reddened hairs had turned white. Finally, all the hair fell off, except a little on the sides and back of the head, and the patient took to wearing a white wig, which contrasted oddly enough with the unchanged blackness of her eyebrows and lashes. In the course of two months, she was restored to her usual state of health.

The relation of cause and effect in these instances, Dr. Raymond thinks, is quite evident. Numerous facts have recently been brought forward which establish beyond doubt the influence exercised by certain nervous lesions, such as those accompanying migraine, neuralgias, paralysis, operative procedures, etc., in producing disturbances in hair-nutrition, as manifested by dryness, abnormal activity of growth, change of color, falling off, etc. There is an increasing tendency of late to connect alterations in the cutaneous nerves with changes in the integument itself, including the nails, hair, and cuticle, and an example of this connection is very clearly presented in the case just given.

IODOFORM IN EXUDATIVE SKIN DISEASES.

The author gives the details of four cases which, in his opinion, occurring as they did among poor people in a country district, bear strong testimony to the efficacy of iodoform in a very obstinate class of diseases.

The first case was that of a robust woman of forty, affected with an eczema of the entire surface, including the face and scalp, of two years' duration. On the legs and thighs the corium was laid bare, and poured forth an abundant exudation. The face was greatly swollen and covered with crusts. In these situations, iodoform was applied as an ointment (2 : 20), while the back, breasts, and scalp were powdered over with a compound of 8 iodoform to 100 amylum. For fear of toxic effects, only about two grams in all of iodoform were employed daily. In ten days a decided improvement was evident, and twenty-four days later not trace of the disease could be discovered.

A lymphatic little girl, eight years old, of enfeebled constitution, had had eczema for a year. Her face was covered by the eruption as by a mask, from fissures in which a dark-brown fluid was discharged. She was scarcely able to eat on account of painful rhagades about the mouth. Iodoform ointment was prescribed, and she received internally cod-liver oil and syrup of the iodide of iron—with the result of a complete cure in four weeks.

In the third case, that of an adult female, the labia pudendæ and inner surface of the left thigh were covered with an exceedingly moist eczema. Three weeks' use of iodoform powder removed the complaint entirely.

The last case was one of a different character, lichen ruber affecting the back of the hands, which were covered with scales and tubercles dotted over with bloody points. By way of instituting a comparative test, the right member was treated with iodoform ointment as above, while Hebra's spirit of soap was made use of for the left. When next seen, after the lapse of two weeks, the right hand was much improved, but on the other extremity the eruption had rather extended. The experiment was continued for ten days longer, at the expiration

of which time the right hand, being now quite well, iodoform ointment was ordered for the left, and in four weeks had removed every vestige of the disease.—PAWLIK, *Wien. Med. Presse*, No. 23, 1882.

BLACK HERPES OF THE LIPS.

The object of this contribution is to remove the uncertainty hitherto existing as to the precise nosological position which should be assigned the affection of which it treats, herpes having usually been described as a mere sequela of other maladies, while, on the other hand, some authorities, among whom Dr. L. is included, claim for it an independent place as one of the eruptive fevers. In support of this latter view, a case is related, of which we present the following outline:

A young woman, aged twenty-one, was seized, three days before her expected first confinement, with a high fever, a bluish gangrenous-looking spot, eight centimetres long by six broad, making its appearance at the same time in the left iliac region. In due course, after a tedious labor, but without any untoward symptom pertaining to the process, she was delivered of a healthy and well-formed child. The fever, however, persisted without abatement. On the same day, an herpetic eruption was noticed on the left commissure of the lips. It consisted of four isolated vesicles, resembling small bullæ, and filled with a blackish fluid. These gradually increased in size and number until, on the fifth day, they surrounded and covered the whole mouth. A portion of the abdominal ulceration, meanwhile, underwent a sloughing process. No gastric disturbance was present, and none of the symptoms appeared to be connected with the generative organs, or to exercise the slightest influence upon them. During all this time, the fever had not remitted for a moment, but continued as intense as before the patient's confinement. Death occurred on the seventh day after the latter event, the intellect remaining entirely unaffected to the last.

In this case, the diagnosis was far from clear until, on the fifth day of fever, the characteristic eruption revealed itself on the lips, announcing a disease somewhat similar to black small-pox, and quite as malignant. The ulcer of the abdomen he considers to have been simply the earliest manifestation of the herpetic morbid principle, its solitary occurrence and well-marked oval shape plainly connecting it with this species of eruption.

The parturient female, no doubt, is particularly predisposed to inflammatory herpes; but that the existence of any disease pertaining to her state is essential to its development, the author regards as a proposition no longer to be supported in view of the observation he details.—LAGOUT, *L'Union Méd.*, June 22, 1882.

HERPETIC FEVER.

1. Herpetic fever, whatever tendency it may manifest, whether to the skin or to the mucous membranes—may be either continuous, remittent, or intermittent in its type.

It may be prolonged by the occurrence of several successive crops of eruptions, and may thus assume the appearance of a remittent or of an intermittent.

2. Herpetic fever may be complicated as follows:

By nervous symptoms, which may simulate cerebro-spinal meningitis, and sometimes cause death.

By articular symptoms, not rheumatic, but appearing to depend upon the infectious nature of the disease.

By bowel-complaints, probably due to the eruption becoming seated upon the gastro-intestinal tract.

Herpes quite frequently co-exists with other species of eruptions (papular erythema, erythema nodosum, urticaria, etc.).

These various complications may occur in association with each other, thus constituting a serious form of the complaint.

3. Cold is not the only cause of the disease; but, like the other causes (excesses, emotions, etc.), it seems to act only through its disturbing influence on the nervous system. This influence, probably, is one of the conditions tending to bring the subject into a state of predisposition with respect to some hitherto undiscovered morbid agent. — GOUDOUNÈCHE, *Th. de Paris*, 1882.

TREATMENT OF VULVO-VAGINITIS IN LITTLE GIRLS.

THE affection described by authors under the name *vulvitis of little girls* is not a simple vulvitis; it is always a *vulvo-vaginitis*.

Infantile vulvo-vaginitis is developed and kept up by insufficient food or unfavorable hygienic conditions, and locally by inattention to cleanliness.

Its distinguishing feature is a purulent discharge, thick, acid, and yellow or greenish-yellow in color.

Although benign and without effect upon the general health, it is usually of long duration.

Treatment should be directed both to the correction of the lymphatic or herpetic diathesis, which lies at the root of the disease, and to the relief of the local symptoms.

The following measures will accomplish the former object:

1st. A bath every other day, containing two pounds of common salt and four ounces of starch.

2d. The administration of tinct. iodine, fifteen grains, and bromide of potassium, forty-five grains, with five ounces of syrup of Tolu—a teaspoonful before each meal.

3d. For drink during meals, a solution of one drachm of bicarbonate of soda to one quart of water.

4th. A mild aperient every week, such as castor oil, mint, etc.

The local treatment consists of injections composed as follows:

Neutral glycerin..... $\frac{3}{4}$ iv.

Sulphate of alumina and potash... gr. xlv.

Laudanum..... gr. xxx.

A teaspoonful in half a glass of water to be thrown up every night and morning.

A pledget of charpie dipped in the same solution should also be kept between the labia majora. — CHEROU, *Le Courrier Médical*, September 23, 1882.

INFLUENCE OF ALCOHOLISM ON THE DEVELOPMENT OF SKIN-DISEASES.

1. Alcohol is neither destroyed nor transformed within the organism, but remains there for a considerable length of time, and is eliminated, in great part, if not entirely, by the kidneys, the lungs, and the skin.

2. The bodily disturbances occasioned by this agent consist partly in an intense congestion of the organs with which it is chiefly brought in contact, and partly in a profound alteration of the tissues and more important nutritive functions, which terminates in the development of a genuine cachexia.

These disorders produce their most injurious effects on certain organs, particularly the skin, thus making it easy to explain the influence exerted by alcoholism upon the several varieties of cutaneous disease.

3. Alcoholism, by its unaided power, is capable of evoking morbid cutaneous phenomena, whose underlying cause, however, is to be sought for in some special constitutional predisposition, *i. e.*, in either the arthritic, herpetic, scrofulous, or syphilitic diathesis. But these effects are seldom met with; and what we most frequently observe, and should always bear in mind, in respect to this condition, is the important part it performs in the maintenance and aggravation of pre-existing disease, to which it sometimes imparts a very serious character.—JAXIN, *Th. de Paris*, 1881.

LEPROSY IN THE ANTILLES AND THE LEVANT.

1. Leprosy is a disease whose nature and mode of causation are still imperfectly understood, but which appears to proceed from an alteration in the nervous system giving rise to corresponding changes in the constitution of the blood.

2. The most obvious cause of this complaint, in the great majority of cases, is hereditary predisposition, although it may undoubtedly be developed under the influence of unfavorable hygienic and climatic conditions, and perhaps even as a direct result of contagion.

3. Leprosy, especially if taken at its commencement, may be treated, with excellent prospect of success, by *hoàng-nân*, which will be powerfully aided in its action by good hygienic surroundings, suitable nourishment, and, when requisite, by a change of climate.—CAVASSE, *Th. de Paris*, 1881.

ECZEMATOUS ULCER OF THE LEG.

DR. WILLARD CHANEY, city physician, Detroit, has had excellent success in the treatment of this disease with an ointment of petroleum and iodoform. A widow, thirty years of age, hard-working, living in damp and illy-lighted apartments, had eczematous ulcer, large as a silver dollar, on the inner aspect of lower third of leg. Anorexia, anæmia, hysteria, with copious sanious discharge from painful ulcer, were prominent symptoms. The doctor ordered her all-day rides in the open air of the Detroit river ferries; to take internally, three times a day, twenty drops of muriated tincture of iron with one-thirtieth of a grain of corrosive sublimate, in suitable vehicle; applied to ulcer daily R unguent. petrolei, ʒ ij.; iodoformi, ʒ j., M.; with firm even pressure by means of roller bandage.—*Mich. Med. News*, October 25, 1882.

Received.

The Treatment of Acute Eczema. By DR. G. H. ROHÉ. (Reprint.)

Ueber Syphilis Maligna. Von DR. EDMUND LESSER. (Reprint.)

Zur Ätiologie der Alopecia areata (Area Celsi) von PROF. DR. WILHELM EBSTEIN. (Reprint.)

Étude critique et clinique sur la Dermatite Exfoliatrice généralisée par DR. L. BROCCQ. Paris, 1883.

Ueber den Arzneigelatineverband und die locale Behandlung des Eczems. Von PROF. DR. FIL. JOS. PICK. (Reprint.)

Ueber den Einfluss des Erysipels auf Syphilis. Von DR. J. STRACK. (Reprint.)

Items.

ANNOUNCEMENT.—The Editors take pleasure in stating that arrangements have been made for the publication of an extended article on the treatment of Eczema, by Prof. McCall Anderson, of Glasgow. It will be the most thorough and practical exposition of the subject that has yet appeared in any language. The first installment will appear in the May number. They will also, at an early date, present a translation of the therapeutical portions of Prof. Gamberini's recent treatise on the Diseases of the Hair and Nails.

REMOVAL OF FRECKLES.—The careful application of a small piece of the ointment of the oleate of copper at night upon retiring will usually remove the freckles. The oleate copper ointment should be prepared by dissolving one drachm of the salt of oleate of copper in sufficient oleo-palmitic acid to make a soft ointment.—SHOEMAKER.

TREATMENT OF SYCOSIS.—

R Kreasoti..... ℥ xx. to xxx.
Zinci oxid..... ʒ iss.
Ungt. simp..... ʒ i.

M.

Apply night and morning.—BOUCHUT.

DIFFUSION OF SYPHILIS BY A MIDWIFE.—Dr. Kline reports that thirty married women, nine husbands, and two infants contracted the disease directly or indirectly from a diseased midwife.—*Brit. Med. Jour.*, Jan. 20, 1883.

ACUTE ECZEMA OF THE FACE IN AN INFANT TREATED WITH TINCTURE OF IODINE.—Dr. Dulles reports (*Med. News*, Feb. 3, 1883) a case in which he used the above treatment with advantage. Two or three applications only were necessary.

VENEREAL SERVICE AT THE CHARITY HOSPITAL.—The number of cases of venereal disease treated at Charity Hospital, New York, during the year 1882, was as follows:

Syphilis.....	671	Chancroids.....	315
Buboes.....	182	Phymosis.....	22
Gonorrhoea.....	218	Epid. and orch.....	63
Total.....	1,471.		

NEW YORK SKIN AND CANCER HOSPITAL.—We welcome the establishment of an institution under the above name, and the professional care of Drs. Bulkley, Fox, Robinson, and Alexander. It is located at 243 E. 34th street. It has issued an appeal to the public for funds with which to sustain and endow it.

ALOPECIA OF THE EYELIDS.—Dr. Buller reports (*Trans. Am. Ophth. Soc.*, 1882) a peculiar case in which the hairs of the upper lids were affected. The hairs were characterized by "the presence of a thread like material wound around the hair, extending from the bulb to a certain distance up the shaft, but never beyond the point of emergence of the hair from its follicle."

DIOXYMETHYLANTHRAQUINONE.—This is the latest name the chemists give to Chrysarobin.

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Original Communications.

THE TREATMENT OF ECZEMA.

BY

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and to the Special Wards for diseases of the Skin.

NO treatment can be more routine and ineffectual than that sometimes adopted for the cure of eczema, and cases of this disease are often allowed to go on for months and years, when judiciously selected remedies might have removed it, in the majority of instances, in as many weeks: for, with some exceptions, there are few diseases more curable than even severe forms of eczema. Of no disease is it more true than of eczema, that there are many ways of arriving at the same goal: some cases may be cured either by constitutional or local treatment, but generally it is advisable to employ a combination of both. The measures to be adopted must, however, vary, according to the age, existing state of health, and constitution of the patient, and according to the seat, extent, severity, and stage of the eruption.

Constitutional Treatment.—It is necessary in this, as in all other diseases, to make a careful examination of the internal organs, and to rectify, as far as it is within the scope of medicine, any deviation from the normal standard which may be detected, and which may be keeping up or aggravating the skin affection. The reader will be aided in this investigation by calling to mind what has been stated with regard to the causes of eczema, and with regard to those states of the system which are most likely to produce or to intensify it. In fulfilling this indication, he must be guided by broad general principles, with which it is

presumed he is already familiar. But a few words may be appended under this head, especially with regard to derangements of the digestive organs.

Purgatives and aperients are often useful in cases of eczema, though they must usually be looked upon merely in the light of adjuvants to, or forerunners of other treatment: for no one who has carefully studied this complaint can have failed to observe the injury which usually follows upon a long course of purgatives, except in cases *entirely dependent upon digestive derangement*. It is true that during their use the eruption may improve or disappear; but whenever they are stopped, it flourishes again as luxuriantly as ever, while that debility which lies at the root of so many cases of eczema is immeasurably increased. A considerable degree of latitude may be allowed in the selection of a purgative, and the remedies with which it may be combined, which must vary with the varying features of different cases; for it is perhaps more true of this complaint than of most others, that, while there are many ways of curing it, there is no rule applicable to the treatment of all cases. If the tongue is loaded, the appetite bad, the liver torpid, as indicated by the light color of the evacuations, etc., and the bowels costive; and if, in addition, the patient is not very strong—small doses of gray powder combined with rhubarb and salicine or quinine may be administered with excellent effect,¹ or sulphate of magnesia in combination with one of the preparations of iron.²

If the disease is in the acute stage, or if the digestive organs are in the state just mentioned, and the patient is robust, and especially if fulness in the hepatic region is complained of, occasional doses of calomel, alone or in combination with scammony, may be resorted to with ad-

¹ R Quiniae sulphatis.....	gr. xij.
Pulv. rhei.....	gr. xxxvi.
Hydr. c. cretæ.....	ʒi.
Sacchari purificati.....	ʒi.

M. Divide in pulv. xij.

Sig. Two daily. (For an adult.) The dose to be so regulated that the patient has at least one full natural evacuation per day.

² R Quiniae sulphatis.....	gr. xlvij.
Ferri sulphatis.....	ʒ ij.
Acidi sulphurici dil.....	ʒ iss.
Magnesiae sulphatis.....	ʒ ij.
Syrupi zingiberis,	
Tinct. aurantii.....	āā ʒ iss.
Inf. calumbæ.....	ad ʒ xxiv.

Solve.

Sig. A tablespoonful in a wineglassful of water thrice daily. The dose of the sulphate of magnesia must be so regulated that the patient's bowels are kept free without his being purged.

vantage.¹ In cases of infantile eczema, small doses of calomel occasionally (gr. i. to a child of a year old) are often of service to correct digestive derangement, more especially if arsenic and iron and tonics generally are being administered; but in no case is it advisable to put patients under the influence of mercury, as is occasionally done, although a trial of corrosive sublimate in small doses, in combination with bark, has been recommended by Fraser and Tilbury Fox, when the patches of eczema are markedly indurated.

With the same object in view, and much more universally employed than calomel, though not nearly so useful, small doses of sulphur, in combination with magnesia or acid tartate of potash, may be taken every evening; and as good a preparation as any is the sulphur confection (*confectio sulphuris*) of the British Pharmacopeia, of which about a tea-spoonful may be prescribed. Besides being less effectual, in my opinion, than calomel, it has this additional drawback, that the sulphur is converted into sulphuretted hydrogen, and the excretions have accordingly a very unpleasant odor. In the opinion of some physicians, it has this advantage over calomel, that it is in part eliminated by the skin, and is supposed to act beneficially upon that structure, so that, according to this view, it possesses alterative as well as purgative properties. A more pleasant and agreeable preparation is a solution of three or four drachms of sulphate of magnesia in water, with the addition of two scruples of bicarbonate of soda, and made to effervesce by the addition of half a drachm of tartaric acid.² This may be repeated every night or every second night.

¹ R Hydrarg. subchloridi..... ℥i.
Pulv. scammonii co..... gr. xl.
M. Divide in pulv. iv.

Sig. One every week. (Dose for one adult.)

Or,

R Hydrargyri subchloridi..... gr. iv.
Mas. pil. coloc. co. gr. v.
Extr. belladonnæ..... gr. i.
M. Divide in pil. ii.

Sig. One at bedtime, and a Seidlitz powder in the morning. (Dose for an adult.)
To be repeated once or twice in the week, if required.

² R Magnesiae sulphatis..... ʒ iv.
Sodæ bicarbonatis..... ℥ij.
Aquæ..... ʒ ij.
M.

R Sacchari purificati,
Acidi tartarici..... āā ʒ ss.
Syrupi limonis..... ʒ ss.
Aquæ..... ʒ iv.

M. Sig. Mix the two solutions in a large tumbler, and drink during effervescence. (Dose for an adult.)

The doses which have been indicated are for adults, and are merely approximative; for, of course, some constitutions are more susceptible of the action of purgatives than others, and care must be taken to avoid the administration of mercurials as much as possible in the case of those with whom they disagree. Not long ago, for instance, we gave a couple of grains of calomel and three of gray powder to a little girl, which gave rise to the most profuse salivation, ulceration of the mouth, and swelling of the gums and submaxillary glands. This is far more remarkable than the production of similar symptoms in the adult, even with the same dose; for as a general rule, as all physicians are aware, it is much easier to salivate an adult than a child. Finally, aperients are often of great value, in combination with tonics (such as the quinine, iron, and sulphate of magnesia mixtures already given), with the view of preventing the latter from constipating the bowels, or otherwise deranging the organs of digestion.

In some cases of eczema, *diuretics* are indicated—in those, namely, in which there is functional derangement of the kidneys, and especially torpidity of these organs. But the beneficial effects of remedies of this class must not in every case be attributed to their diuretic action merely; for example, it is very probable that alkaline diuretics, as the bicarbonate, or neutral, which are converted into alkaline salts in the system, as the acetate of potash, do more good in virtue of their neutralizing excessive acidity of the system.

Having attended to the condition of the internal organs in general, and of the digestive organs in particular, the internal treatment now radiates in two directions, according as the eruption occurs in those who are apparently otherwise in robust health, or in those who are chlorotic, anæmic, scrofulous, or debilitated.

In strumous subjects, nourishing food, stimulants in moderation, tonics (especially phosphorus and iron), are our sheet-anchors, and we have repeatedly cured very severe cases of eczema by the systematic administration, for a couple of months, of cod-liver oil and syrup of the iodide of iron, all other treatment of importance having been omitted. The following is a case in point:—"Lawrence D., aged about fifteen months, was brought by his mother to the Dispensary for Skin Diseases, Glasgow, on October 9, 1862, affected with eczema impetiginodes. The eruption covered almost the whole body, with the exception of the fingers and the feet, was very itchy, constantly exuding, and studded with crusts. The child was dreadfully emaciated, 'just skin and bone,' as the mother remarked. It could neither sleep nor eat, and was so weak that it had to be brought upon a pillow. The case looked hopeless, and, indeed, the child had been given up by the previous attendant; but acting upon what I have observed in similar cases, twenty drops of syrup of the iodide of

iron in a teaspoonful of cod-liver oil were prescribed, to be repeated thrice daily, and the dose of the oil to be gradually increased to a tablespoonful.

"On October 16, the child was better. The skin being still itchy, however, a lotion of dilute hydrocyanic acid, containing fifteen minims to the ounce of water, was ordered, to be used thrice daily as a palliative. The oil was omitted for a week, as it produced purging. With this exception, the oil and iron were steadily continued till November 17, about five weeks after the commencement of the treatment, when the mother brought the child out of gratitude to show how well it was. There was hardly a vestige of the previous eruption, with the exception of a few dry crusts and discolored spots on the buttocks, which were rapidly disappearing. The child appeared to be in robust health; it was quite plump, and its cheeks rosy; its skin soft and white; its appetite very good; and its sleep sound and refreshing. The medicine was to be continued for another month."

Here, then, is an instance of an infant cured of a frightful eczematous eruption, and rescued from the jaws of death, by the internal administration of cod-liver oil and iron alone. In severe cases such as this, it is of decided advantage to rub the oil into the skin of the whole body two or three times a day, in addition to its administration internally. Cod-liver oil is sure to do good to these patients if the stomach can bear it, and especially if it is taken greedily and with relish. This is oftenest observed in children whose mother's milk is below par. When such is the case she should no longer give her child the breast, and amongst the higher classes, who can afford to have a wet-nurse, a good one should at once be procured. Amongst the lower orders, the child should be fed, in great part, "upon the bottle," a mode of nourishment which, though inferior to the employment of a good wet-nurse, is much more desirable, when proper precautions are taken, than the exclusive use of the deteriorated milk of the mother. Those children whose health has been impaired by imbibing their mother's milk too long—and instances are often met with, especially amongst the poor, of children being fed upon the breast, not for months, but even for a couple of years—should be weaned without delay, and appropriate nourishing food substituted.

These children often suffer from diarrhœa, but while special remedies, guided by general principles, may be cautiously employed towards its removal, one must remember that it is often the result of debility, in which case it may be expected to disappear spontaneously when the diet is altered and the general health improved.

In adults, under similar circumstances, cod-liver oil and iron are almost equally serviceable, and in them, as well as in children, small quantities of stimulants may in some cases be superadded, though it is generally advisable to use them with caution.

Some patients, and adults oftener than infants—for the latter rarely refuse it, after the correction of any digestive derangement which may be present, if the system really requires it—cannot take cod-liver oil, in which case cream may be substituted, through it is not to be compared with it in efficacy; and while taken with relish at first, it is more likely to derange the stomach in the long run. So that if the case is undoubtedly one which calls for the use of the oil, it does not do to let the patient put it aside lightly, but repeated trials of it in various doses and forms must be made, and the bowels must always be carefully regulated before administering it. Sometimes it is tolerated better by swallowing a small pinch of magnesia about half an hour after the oil is taken, as was recommended lately in some of the medical journals, or by putting a little salt on the tongue immediately before it is administered.

It occasionally happens that cod-liver oil is better tolerated when given in combination with tonics, as quinine or syrup of the iodide of iron. Patients who have an unconquerable repugnance to the oil itself may try it in the shape of Kepler's malt extract with cod-liver oil, or Makenzie's (of Edinburgh) compound cod-liver oil emulsion, or Furley's cod-liver oil cream, or cod-liver oil chocolate, introduced by Erasmus Wilson (and manufactured by M. Lesaigue, 9 Langham Place, Portland Place), each pound of which contains four ounces of oil; or it may be given in a concealed form, as in the appended formula.¹

Before leaving this subject, it may be remarked—although it is hardly necessary after what has just been stated—that we dissent from the opinion of Hebra that “cod-liver oil, although of the greatest service as a local application, is quite useless when given internally.”² Indeed, no one who has carefully studied the writings of this distinguished dermatologist can have failed to have observe that, while he lauded, and with justice, the local treatment of skin diseases, he was too apt to depreciate the influence which internal remedies exercise over these complaints, although latterly his views in this respect seem to have undergone considerable modification.³

℞ Liq. potassæ.....	℥v.
Ol. morrhue.....	℥ ss.
M. et adde,	
Tr. cort. aurantii,	
Syr. aurantii.....	āā ʒ i.
Olei amygdalarum amarum.....	℥i.
M.	

² “On Diseases of the Skin, Including the Exanthemata,” by Ferdinand Hebra, M.D. Translated and edited by C. Hilton Fagge, M.D., and P. H. Pye-Smith, B.A., M.D., 1868, vol. ii., p. 143.

³ When the formation of pus is a prominent feature, and particularly when the disease is complicated—as so often happens—with furunculi (boils), the hypo-

When the appetite is very deficient, a pure tonic may be substituted for a ferruginous one with advantage, such as small doses of quinine and sulphuric acid in a bitter infusion;¹ or, if the stomach is too weak even for this, a little dilute hydrochloric acid alone may be tried in doses of ℥viij., or a teaspoonful of Benger's Liquor Pepticus in a wine-glassful of water thrice daily after food; these are usually well borne and aid digestion.

In anæmic cases it is the universal custom to prescribe iron, but for our part, although we do not wish to assert that it is inert, its virtues in these cases have been enormously overrated, and there can be no question that arsenic (of which more hereafter) is infinitely more powerful; but while we believe this to be true with regard to cases of undoubted anæmia, there can be no question that in cases of pure chlorosis, iron, given in sufficient doses, is the remedy *par excellence*—is, in fact, an absolute specific. It is not, however, every preparation of iron which can be tolerated by the stomach in sufficient quantity to correct the blood disorder, but that which we have found most efficient is Bland's pills, the formula for which is undernoted.² But let us now take the opposite class of cases (and very common they are) in which the patients are neither chlorotic, anæmic, serofulous, nor debilitated, but, on the contrary, appear, with the exception of the eruption, in a good state of health. In such instances, what means of operating on the system at large are we justified in having recourse to?

Some recommend the extraction of blood by means of the lancet, but this is surely never necessary; indeed, we have neither had recourse to it sulphite of soda or the sulphide of calcium may be given; the former is administered dissolved in water in doses of from gr. 20 to 30, three times a day for an adult; the latter in the form of pills, each of which contains gr. $\frac{1}{4}$, and may be taken three times a day: or the medicine may be given in the appended form, in which case it should be made up fresh every day.

℞ Calcii sulphureti. gr. iss.

Aquæ destillatæ. ʒ iss.

M. Sig. Shake the bottle. A teaspoonful every two hours.

¹ ℞ Quiniæ sulphatis. gr. xvi.

Acidi sulphurici aromatici ʒ iv.

Syrupi limonis. ʒ ss.

Inf. cascariellæ. ad ʒ viij.

M. et cola per chartam. Sig. A tablespoonful twice daily, half an hour before food. (Dose for an adult.)

² ℞ Ferri sulphatis,

Potassæ carbonatis,

Potassæ tartratis. āā ʒ ss.

Tragacanth. q. s.

M. Divide in pil. xlvij. Six pills to be taken daily. It is usually preferable to divide the pill-mass into double the number of boli prescribed by Bland, in which case, of course, twelve pills instead of six must be taken in the day.

ourselves, nor seen it employed by others; for while many severe and extensive eruptions in plethoric persons have come under observation, we have found purgatives—especially mercurial and saline purgatives—answer all the ends in view. The local abstraction of blood by leeches, cupping-glasses, or scarifications has sometimes been resorted to with advantage, if the patches of eruptions are very acutely inflamed, and especially if the lower extremities are affected, as these parts, for reasons formerly mentioned, are more liable than others to congestion and its results. But even local bleeding may be dispensed with, although we are aware that this opinion will be regarded in the light of a heresy by a few.

In the cases which we are now considering, and applicable, to a certain extent, to the class previously mentioned, in conjunction with the means then recommended, there are certain internal medicines upon which considerable reliance may be placed, and to which allusion must now be made. Of nerve-tonics, those which are most likely to be useful are strychnia and arsenic.

STRYCHNIA may be given alone or in combination—*e. g.*, in the shape of Eaton's Syrup,¹ of which the dose is a teaspoonful three times a day, in a glass of water before food, or in the sulphate of magnesia mixture already mentioned, substituting liquor strychniæ in doses of ℥iij.—v. for the quinine and sulphate of iron; a very good preparation, too, when iron is also indicated, and when there is no constipation, is Young & Postan's granular effervescing iron, bismuth, and strychnia, of which a teaspoonful may be given in a wine-glassful of water thrice daily before food.

Of ARSENICAL PREPARATIONS, the one which is most used is Fowler's solution (liquor arsenicalis), although any of the others may be selected, according to the taste of the practitioner. It is better, however, for the physician to limit himself as much as possible to one preparation of arsenic, for he thus becomes more familiar with its exact mode of operation, and with the probable doses for different constitutions. He must also satisfy himself, before prescribing it, that there is no derangement of the digestive organs, else the remedy is pretty certain to disagree; and, further, if it aggravates in a marked degree the cutaneous irritation (the itching, heat, etc.), which it is pretty sure to do in the acute form, it is a proof that the disease is not in that stage in which benefit is likely to be derived from it. It is now well known, as first pointed out by Hutchinson, that persons taking arsenic are very liable to be affected with zona (herpes zoster), and if it occurs it is advisable to omit the use of the remedy until the rash has completely disappeared. An adult may take from three to five minims thrice daily, and if, after the continuance of this dose for

¹[Equivalent to the Syrupus Ferri, Quinæ, et Strychniæ Phosphatum of the U. S. Ph.—Ed.]

several weeks, no improvement takes place, and it appears to suit the patient in every respect, it may be gradually increased till the disease begins to yield, or until it begins to disagree. We do not think it necessary to stop it if slight irritation of the eyes or puffiness of the face is induced; but if these symptoms are at all aggravated, and especially if they are accompanied by pains in the stomach and head, anorexia and nausea, bronchitic irritation, or a feeling of great lassitude and prostration, the dose should be diminished, or in some cases omitted, for a few days. On no account, however, should its administration be stopped altogether because these symptoms are produced; and we indorse in a measure the statement of the late Dr. Begbie that "in order to secure its virtues as an alterative . . . it will be necessary to push the medicine to the full development of the phenomena which first indicate its peculiar action on the system. Arsenic as a remedy is too often suspended or altogether abandoned at the very moment when its curative powers are coming into play. The earliest manifestation of its physiological action is looked upon as its poisonous operation; the patient declares that the medicine has disagreed with him; forthwith the physician shares his fears; the prescription is changed, and another case is added to the many in which arsenic is said to have failed after a fair trial of its efficiency."¹ It is necessary to observe that the appropriate dose of Fowler's solution varies in different individuals, and that, while three minims thrice daily soon disagrees with some, ten, fifteen, or even twenty may occasionally be taken by others with impunity and with benefit. We have repeatedly had occasion to observe—what has not, as far as we are aware, been previously noted—the great liability of patients to catch cold while taking arsenic; and we have so frequently seen bronchitis developed during an arsenical course, as to leave no doubt in our mind of the cause of it. It is therefore even more necessary to warn patients who are taking an arsenical, than those who are being subjected to a mercurial course, of their liability to catch cold.

To prevent the medicine from deranging the stomach, it may sometimes be necessary to give it *during* or *immediately after* meals, and in persons whose digestive organs are weak, a tonic infusion, such as the infusion of cascarrilla, gentian, or calumba, forms a very good vehicle for its administration, while in some cases a few drops of morphia may be superadded² if there is a tendency to diarrhœa.

¹ Dr. Begbie's article "On the Physiological and Therapeutical Effects of Arsenic" will well repay perusal. See his "Contributions to Practical Medicine," p. 270. Edinburgh: Adam and Charles Black, 1862.

² R Liqueoris arsenicalis ʒ iss.
 Liqueoris morphiæ hydrochloratis ʒ i.
 Syrupi limonis ʒ iss.

As the disease yields, the dose may be gradually diminished, but in no case should the medicine be suspended till some time AFTER THE COMPLETE REMOVAL of the eruption.

In the case of infants at the breast, it may be administered to the mother, whose milk thus furnishes not only nourishment to her babe, but likewise an antidote to its complaint. But it is much more certainly efficacious when administered directly to the child. In infants about six months old, the initial dose should be one minim twice or thrice daily, while in children from one to two years of age, we may commence with safety with one and a half minim, and the dose should, if necessary, be gradually increased; for children, as a rule, can tolerate proportionately larger doses than adults.

In some cases, it is thought advisable to combine arsenic with mercury, as in Donovan's solution (solution of the hydriodate of arsenic and mercury), of which ten minims is the dose to commence with. Each drachm of the solution contains about one-twelfth of a grain of oxide of arsenic, one-fourth of a grain of oxide of mercury, and five-sevenths of a grain of iodine, in the state of hydriodic acid in chemical combination.

And sometimes it is recommended to prescribe arsenic along with iodine, and without mercury, in which case Neligan's prescription, which he names the ioduretted solution of the iodide of potassium and arsenic,¹ is a suitable one, and is much used.²

We rarely prescribe either of these, however, at the present time; and we very much suspect that in most cases in which arsenic has failed by itself, but has done good in combination with mercury or iodine, there has been an error of diagnosis, a syphilitic having been probably mistaken for an eczematous eruption. But very often the greatest benefit accrues from combining arsenic with iron, and in the case of those whose stomachs are irritable, it may be well to give in effervescence, as in the appended formula,³ or in the form of Young and Postan's granular

Tinct. cocci..... ʒ ss.

Infus. cascarillæ..... ad ʒ xij.

M. Sig. A tablespoonful thrice daily after food.

¹ B Sol. Fowleri..... ℥ lxxx.

Iodidi potassii..... gr. xvi.

Iodini..... gr. iv.

Syrupi florum aurantii ʒ ij.

Sig. A teaspoonful, in a wine-glassful of water, thrice daily.

² "Medicines: Their Uses and Mode of Administration," by J. Moore Neligan,

M.D. Ed. iv., p. 465, Dublin.

³ B Ferri citratis,

Sol. Fowleri..... āā ʒ iss.

Acidi citrici..... ʒ vi.

Aquæ destillatæ ad ʒ vi.

M.

effervescing iron and arsenic, which is a very pleasant and useful preparation, and the dose of which is a teaspoonful in a wine-glassful of water thrice daily.

We sometimes give arsenic, and we think with good reason, in a concealed form. For instance, we know of a lady for whom Fowler's solution was prescribed, who, finding that she was improving under its use, increased the dose of her own accord, and thereby induced poisonous symptoms. Some time after this, she consulted Cazenave, and on her return from the Continent, she came to her family physician, and informed him that she had never been able to take arsenic since she had administered to herself the overdose. The doctor, on looking at Cazenave's note, found that she was at that very time taking arsenic without knowing it, under his orders, and with good effect. Then, again, some people who consult us have already tried arsenic without benefit, and either refuse to take it again, or are so skeptical of its efficacy that they are apt to take it with great irregularity, and to be convinced in their own minds that they are to derive no benefit from it—conditions which are very prejudicial to the due operation of any drug.

Very often, in these cases, the previous arsenical course had been improperly carried out, or not continued sufficiently long, and we are thus compelled either to give it in a concealed form or to dispense with the use of a most powerful therapeutic agent. Exception has been taken to the propriety of the recommendation to conceal from patients occasionally that they are taking arsenic. This is a feeling with which, for our own part, we have no sympathy. Surely all that our patients can ask of us is to do everything in our power to benefit them. Besides, those who have called us to task for recommending such a course are surely acting in a similar manner when they prescribe an opium pill under the title of "*Pilula saponis composita*," which is described in *Neligan's "Materia Medica"* as "a convenient preparation for ordering opium in the pilular form, under a name by which it is unlikely to be recognized by the public."

ALKALIES are not nearly so generally employed as the preparations of arsenic in the treatment of eczema. They are most beneficial when the patient is much addicted to the use of stimulants, and when there is a tendency to acidity of the stomach and to the deposit of lithates in the urine, or to rheumatism or gout. The preparation most in vogue is

R Potassæ bicarbonatis.....	3 vi.
Tr. cort. aurantii	℥ ss.
Syr. aurantii.....	℥ iiij.
Aquæ destillatæ.....	ad ℥ vi.

M. Sig. Put a glassful of water in a tumbler, add a dessert-spoonful of each bottle, and drink during effervescence. Repeat thrice daily.

liquor potassæ, which may be given, largely diluted with water, in doses of twenty minims thrice daily to an adult. That which we are most in the habit of using, however, and which has not, we think, been tried hitherto for such a purpose, is the carbonate of ammonia, in doses gradually increasing from ten up to thirty or even forty grains thrice daily, care being taken that the preparation is fresh and of full strength. A dose of forty grains is often borne well by a patient whose stomach has been gradually accustomed to its reception, while a smaller dose often occasions vomiting in the case of those who have not been in the habit of taking it. Sometimes it is well to combine the ammonia with Fowler's solution or one of the other arsenical preparations. If there is a decidedly gouty tendency, small doses of wine of colchicum (say five to seven drops), and in rheumatic habits, the acetate, bi-carbonate, or citrate of potash (in half-drachm doses), may be added to each dose. The alkalis must be given largely diluted with water, and the dose must be gradually increased till the medicine disagrees or the eruption begins to fade.

As is well known, the internal administration of TAR, which at one time seems to have had a certain degree of reputation, has almost completely fallen into disuse in the treatment of disease, and till recently I accepted without reservation the verdict of the profession against it. But if there is one thing which has struck me more forcibly than another in the treatment of skin diseases it is the wonderful influence which the local application of tar exercises on chronic eczematous eruptions, of which more hereafter; and in reflecting upon this remarkable fact I could not but conclude that the action of the tar is not a mere local one, but that it is absorbed, reacts upon the system at large, and through it upon the skin.

Hence I determined to give a fair trial to it internally in eczema and psoriasis. At this stage of the inquiry, it would ill become me to dogmatize, but I can only state, as an undoubted fact, that marked benefit has resulted in many cases—in some of them after arsenic and various kinds of local applications had failed, and in which I administered the tar as a *dernier ressort*. I generally commence with two drops of purified *pix liquida* mixed with one-eighth part of rectified spirit, thrice daily, in the case of adults, and gradually increase the dose, if necessary, to thirty or forty. Sometimes I recommend the medicine to be dropped into a spoonful of treacle or golden syrup, sometimes I prescribe it in the form of pills,¹ or in capsules. It generally agrees well,

¹ R *Picis liquida*..... 3 ij.

Pulveris glycyrrhizæ..... q. s.

Divide in pil. lx. Argent.

Sig. Two pills to be taken thrice daily, and the dose gradually increased.
(Dose for an adult.)

but occasionally it produces a copious red rash upon the skin, accompanied by fever, or nausea, vomiting, and diarrhœa, and other evidences of digestive derangement. These disagreeable accompaniments, however, soon pass off when the medicine is stopped, and then, with a little humoring, it may be recommenced and given with safety in gradually increasing doses.

It is in the dry form of eczema, occurring in apparently otherwise healthy subjects, that tar is most likely to be serviceable, but it must be admitted that it is not nearly so certainly useful in eczema as in psoriasis, in which disease its efficacy is sometimes very remarkable.

Of late years, CARBOLIC ACID has been much employed internally, and sometimes with benefit. It is indicated in the same class of cases, although it is not, as a rule, such an active remedy. It may be given either in pill or in solution,¹ and the patient should be warned not to be alarmed if slight giddiness follows its administration, especially when taken before breakfast.

SULPHUR has long been esteemed one of the most valuable alteratives which we possess in the treatment of skin diseases, and especially of eczema; but my own experience leads to the belief that it has little power as an alterative, and that, apart from its purgative properties, it is comparatively useless in the treatment of eczema, unless in rheumatic subjects. If a course of sulphur is to be taken, it is usually advisable to prescribe one of the natural mineral waters containing it; and the fact that some of these do not act as purgatives, and yet are beneficial, must not be taken to disprove my assertion, with regard to the *modus operandi* of sulphur, for the benefit which accrues is due to the combination of salts held in solution, as well as to the accompaniments, rest, change of air and scene. Those of Harrogate and Moffat in Britain, and of Aix-la-Chapelle, Enghien, Baréges, and Luchon on the Continent, have the greatest reputation in this respect; and while some of these waters may be had from the apothecary, it is always more judicious, when it can be effected, to send the patient to the spring itself: for he is thus certain to get the waters fresh and pure, and, away from home and the fatigues and anxieties of business, his body is at the same time invigorated, and his mind refreshed.

As regards Harrogate, which is the most celebrated of the spas of England, its purgative waters are very useful in the case of those whose digestive organs have been upset by sedentary habits, free living, and

¹ R Acidi carbolici.....	3 iij.
Glycerini.....	3 i.
Aquæ destillatæ.....	3 v.

Solve. Sig. A teaspoonful in a large wine-glassful of water thrice daily, on an empty stomach.

constipation of the bowels; and this health resort is doubly valuable from the fact that it affords not only strong but also mild sulphurous waters, suitable to different habits of body, and saline chalybeate, and chalybeate springs, of which one, the chloride of iron spring (or Dr. Muspratt's chalybeate), acts as a tonic, while another, the Kissingen spring, owing to its being richer in saline ingredients, acts as an aperient as well as a tonic in suitable cases. For further particulars I must, without being supposed to indorse all the views which it contains, refer the reader to the little volume published by my friend Dr. Myrtle, of Harrogate, on the mineral waters of that place.¹

In conclusion, I would remark that, while some cases of eczema yield to mineral waters after other means have failed, care must be taken not to overrate their advantages; for there can be no doubt that if, in the treatment of eczema in general, one were restricted either to mineral waters or to ordinary medicinal treatment, the former are not for a moment to be compared in efficacy with the latter, provided it is carried out with discrimination and skill.

HYDROCOTYLE ASIATICA has been greatly extolled of late, especially by the French, in the treatment of eczema. It has been very little used, however, except in France, although, if we may judge from the high encomiums which have passed upon it by our Continental brethren, it seems worthy of a trial.

Before leaving this branch of the subject, it may be well to recall four rules which must be carefully attended to in the employment of the so-called alterative medicines:

1st. Let the dose, at first small, be gradually increased till the medicine disagrees, or till the disease begins to yield, and then let it be gradually diminished.

2d. If the medicine disagrees, do not omit it altogether without very good reason, but try it in smaller doses or in another form, or omit it for a few days till the bad effects have passed off.

3d. To give it a fair trial, it must be continued for a considerable period of time, because in some cases the eruption does not disappear till after it has been administered for many weeks.

4th. Do not, as a rule, permit the patient to give up taking the medicine till some weeks have elapsed since the complete disappearance of the eruption.

Quite recently² Dr. Henry G. Piffard, of New York, has written a paper recommending the internal administration of *viola tricolor*, a drug first introduced to the notice of the profession by Strack in a monograph

¹ "Practical Observations on the Harrogate Mineral Waters." By Andrew Scott Myrtle, M.D., Harrogate. London: Churchill. 1867.

² The Medical Record, April 29, 1882.

entitled "*De Crusta Lactea Infantum Ejusdemque Specifico Remedio Dissertatio*," published at Frankfurt in 1779. The latter used it in the form of an infusion, while the former at first gave it—as advised by French writers, especially Hardy—mixed with senna in the proportion of two parts of viola to one of senna. Now, however, he prefers a fluid extract made by the "repercolation" process, using very dilute (twenty-five per cent) alcohol as the menstruum. In medicinal doses it causes little systemic disturbance, but increases the flow of urine, the odor of which is peculiar, somewhat resembling that of the cat. In acute cases he gives from one to five drops to young children, and from five to ten drops to adults in a little water, once, twice, or three times a day, half an hour before meals. In subacute and chronic cases, ten to fifteen drops may be given to commence with, to the former, and from half a drachm to two drachms to the latter. If improvement follows, the initial dose is maintained; if not, it is increased; while, if it aggravates the disease, the medicine is stopped for a few days and then resumed in smaller doses. It should be continued, or increased, if necessary, "until the eruption begins to show signs of activity—that is, until a decided aggravation is imminent." He considers it most useful in the second stage of the disease, with serous or sero-purulent exudation and crusting, and he knows "of no other drug that, singly and alone, is capable of affording so much relief." When, however, the eczema has reached the dry stage, it does not prove as useful as some other drugs. He thinks that its virtues are probably due, in part, at least, to the salicylic acid which it contains.

It has already been stated that the local inflammatory action and febrile disturbance set up by vaccination is calculated to call forth an eruption of eczema in those who are so predisposed, and to aggravate existing attacks; so much so, indeed, that the operation is frequently delayed for many months on this account. And yet it must be admitted that in some chronic and inveterate cases it has precisely the opposite effect, and may therefore be ranked as a curative agent. As an illustration of this, two cases reported by Mr. Lawson Tait¹ may be mentioned. "The first," he says, "was the child of a commercial gentleman of great intelligence, who allowed me to try vaccination after everything else had been done that could be suggested. It was a most obstinate case of eczema over the whole body, the scalp being the seat of its worst display. The glands of the neck were chronically enlarged, and at one time suppurated so seriously as to endanger the child's life. Temporary benefit was derived from change of air, but drugs had no effect. Acting on the usual rule, I put off the vaccination of the child for three several periods of nine months. . . . I told the father that . . . I believed vaccination

¹ *British Medical Journal*, January 27, 1882, p. 92.

might cure the child by exercising some influence on its nutrition. He agreed to the experiment; and, to diminish risk as far as possible, I used lymph which had passed through one healthy child from the heifer. The result was most remarkable, for in a few days a marked improvement was visible in the child; and in little more than three weeks all traces of the eruption had disappeared, save a roughness of the skin, which still exists. The hair grew rapidly on the scalp, and the child now is in all respects as fine an infant as I have ever seen.

“At the same time I had under my care the child of a clergyman, for which many prolonged and various courses of treatment had been adopted ineffectually for an eczematous eruption affecting the whole body, but mainly the face and flexures of the joints. It was nearly two years old, and had never been vaccinated. I told the father of the case I have just related, and he consented to the vaccination. He has sent me the following note of the history: ‘To the best of my recollection, the symptoms of skin disease in baby were first manifested when she was about two months old. The disease appeared in a virulent form for the space of nine months, at the end of which time she was vaccinated. After vaccination the child improved rapidly, and in a month not a trace of the malady was left.’” Of course it is only in exceptional cases that such happy results can be expected.

Of late years, ELECTRICITY has sometimes been resorted to in the treatment of chronic eczema, either by the direct application of the electrodes to the affected patches, or by applying them to other parts of the body, such as the spine, hands and feet. In the former case the interrupted, in the latter the continuous current should be used; and occasionally benefit accrues from the use of electric baths, especially in neurotic cases. The tonic effects of electricity are undoubtedly of some value, but I am not inclined to rank very highly the effects of this therapeutic agent in the majority of cases.

(To be continued.)

BALANO-POSTHITIS OF DIABETICS.—Prof. Simon specially recommends cleanliness, and after each micturition, lotions feebly charged with phenol, and after drying the part, powdering it with the following:

R. Oxide of zinc.	25 parts.
Starch	25 "
Salicylic acid	1 part.

M.

HERPES ZOSTER (PURPURIC).

BY

CHARLES W. DULLES, M.D..

Surgical Registrar to the Hospital of the University of Pennsylvania; Surgeon to Out-Patient
Department of the Presbyterian Hospital.

A CASE of cutaneous disease has recently come under my care which I think it worth while to put on record, because I have failed to find, in the books on skin diseases which I have consulted, any description which closely resembles it.

The patient, Miss K., is eighty-three years old, thin, with dry skin, and of a well-marked senile type and somewhat hypochondriac. Before the trouble I am about to speak of appeared, she had been suffering with chronic bronchitis, and at the time had had a recent attack of indigestion with some adynamic symptoms, for which for three days she took turpentine, in ten-drop doses, thrice daily. As she was better of this, on January 17, I ordered her pills of *assafœtida*, which she took for two days as well as ten grains of bromide of sodium at bed-time to quiet her restlessness. On January 19, I found her complaining of having suffered for the past two days with severe pain in the upper part of the right chest. On examining her body, I discovered an eruption scattered over the skin along and below the line of the clavicle, around the cap of the shoulder, and occupying the posterior cervical triangle up to the root of the hair. This consisted of scattered blotches of various sizes, from that of a small shot to an inch in diameter, red in color, with clear skin between. After a few days, the whole of the right side of the neck, the right chest-wall to the level of the spine of the scapula behind and the fourth rib in front, and the shoulder over the position of the deltoid was covered with a diffuse red rash in which the blotches were distinguishable by moderate elevation, induration and vesiculation, together with a coloration to which I shall presently allude. There was also just below the root of the hair, on the nape of the neck, a well-marked oblong patch of decided induration covered with closely-crowded small, flat vesicles. Similar vesicles, so minute as to require careful scrutiny to distinguish them, made up the blotches referred to. The contents of the vesicles were clear, the shape of the blotches in some cases was regular and well-defined, in others streaky and like splashes of ink. Their most peculiar characteristic, however, was a slate-blue color, the color so often seen in *purpura hemorrhagica*. When I came to examine closely, I found that this coloration was not due to ecchymosis, but apparently to stasis in the dilated capillary vessels of each patch. At some of the points where the vesicles had coalesced I found a very shallow blister with a flattened blue centre and a narrow, whitish rim, slightly elevated, suggesting the appearance of a mature *vaccinia* vesicle. In a few days more the rash began to disappear, the red becoming duller and the patches more like the surrounding parts, while the vesicles had pretty generally coalesced and broken, leav-

ing a thin veil of cuticle resting on the moist, deeper layer of the skin. The pain now gradually diminished, and the patient convalesced, with the separation of scales and crusts from the vesicular patches. The whole time from the beginning to convalescence was about ten days.

The treatment consisted of keeping the bowels clear, some liquor ammonii acetatis and—what seemed to act very promptly—phosphide of zinc in doses of a quarter of a grain, thrice daily. Locally, calomel was dusted on, and proved only somewhat soothing, though my patient was a very querulous person, and often made it hard to tell just how she felt.

My friend, Dr. Stelwagon saw the case once with me and gave me the benefit of his experience as a specialist in skin diseases. He agreed that there was no disorder with which it could be well classed, except herpes zoster, and indorsed the line of treatment employed.

As I am not a specialist I do not venture to express any strong opinion in regard to this case, but I desire to call attention to its points of resemblance to herpes zoster and then to its peculiarities.

Like herpes, were the acute pain (not itching), the limitation to one side and to a definite area of nerve distribution—that of the ramifications of the cutaneous branches of the cervical plexus—the vesiculation, and (shall I say?) the effect of the phosphide of zinc. Peculiar were the diffuse redness of the skin, the close packing of the vesicles, their flatness, and the singular blue color of the patches. The striking character of this I cannot, perhaps, convey to others, but it was to me very remarkable.

Was I right in regarding this as a case of herpes zoster? And is it proper to call it “purpuric?”

Society Transactions.

NEW YORK DERMATOLOGICAL SOCIETY.

135TH REGULAR (ADJOURNED) MEETING, APRIL 3, 1883.

DR. E. B. BRONSON, *President, in the Chair.*

THE TREATMENT OF ECZEMA.

DR. WEISSE said that he had selected this subject for discussion because he believed that the evening might be very usefully devoted to an interchange of the views of the members upon it. Eczema is a disease the treatment of which is often difficult and intricate, but is also usually very satisfactory in its ultimate results. Considering the affection not from a histological or pathological, but solely from a clinical stand-point, his experience had led him to look upon it as the result of malnutrition, in the majority of instances. The existence of this condition he had been able to determine in all the various phases of the disease, having found that it was direct in early life, and indirect, or the result of im-

proper disassimilation, in those of more advanced age. In nursing children, he had often found that the patients did not get enough food; having failed to reach the root of the trouble by local treatment, until he investigated the supply of breast milk, and finding this insufficient or of poor quality, the addition of cow's milk, or condensed milk, to the food had almost invariably resulted in enabling him to control the disease. Infantile eczema was also often benefited by some form of iron, the patients being usually more or less anæmic. With regard to the condition of the affected skin, scratching always played an important part, adding a state of traumatism to the changes already existing. He thought that local treatment was always necessary in this disease, and the most reliable agent with which he was familiar was hot water, used freely for ten minutes or longer, three or four times daily, and continued until decided improvement in the condition of the skin was produced. If the parts were in a moist, weeping condition, or if scabbing were present, he had found the subnitrate of bismuth (not mixed with lycopodium or starch, but pure), and freely dusted on the skin from a dredging-box, of great value. These two remedies had always served his purpose admirably in infantile eczema.

After this time, up to the period of puberty, the disease is less common. It seemed to depend on bad nutrition at this time of life also, and he was in the habit of improving the dietary of patients, and prescribing cod-liver oil, iron being also of value. Here, too, he was in the habit of advising the free use of hot water (not warm, but as hot as the patients could bear), in the form of douches, and the application of the subnitrate of bismuth. When the dietary of patients could not be improved, he usually gave large quantities of cod-liver oil, and some of the preparations of beef, either the essence or the extract.

About the period of puberty, especially in women, an eczematous tendency often asserts itself, the disease then proving very rebellious to treatment, until the menses become regular. This tendency to eczema he had found particularly well marked in those who had grown very rapidly, the factor of malnutrition playing an important part here also. Hot water and bismuth he had always found of great value in this form of eczema as in the others. Such patients usually require iron. These measures should be employed until the disease had reached a passive condition, one of redness and scaliness without exudation, when stimulants were indicated, the best being a certain preparation of tar painted upon the part.

In adult life he had found eczema less common in the diffused form, but much more frequent in the localized variety, occurring most commonly about the hand and fingers, the attacks varying in severity and extent in different winters (the season in which they are most common). The scrotum was in his experience frequently the seat of the disease, rarely, however, in men under thirty-five years of age. Cases of this kind he believed to be due not to direct malnutrition, but rather to a condition of suboxydation of the system, characterized by the retention of effete products, urea, etc. Such patients usually do well under the use of alkalies internally, the best being, in his experience, liquor potassæ, beginning with doses of ℥℥xx. and increasing to as much as ℥℥i, three times daily. In case the patients cannot tolerate the drug in water, he was accustomed to order it to be taken in lemonade, which not only facilitated its use, but also supplied a certain amount of potash salts.

He had long since abandoned the use of arsenic in eczema after thorough trial of the agent, having found that it had almost no effect in modifying the course of the disease.

Local treatment should, of course, be carried on with the internal alkaline med-

ication. When there is no exudation or scabbing, and the patches had assumed the erythematous and desquamating condition, he usually employed hot water to diminish the infiltration, and afterwards stimulated the parts by the local application of tar, painted on as often as the patient could stand it. In eczema of the scrotum, the itching was always relieved by hot water, particularly when the bicarbonate of soda was added to it (3 i. to O.i.). After this application, he was in the habit of ordering the patient to dredge the part with the bismuth powder, and then to put on a linen suspensory.

In all varieties of the disease, he attended to the condition of the bowels, and often found it beneficial to produce repeated watery evacuations, for which purpose he thought senna and wild violets, after Hardy's formula, the best agent. Rochelle salts are also usually well borne.

In eczema occurring in old age, a condition of malnutrition was also usually present. Such cases are often rebellious, the disease being diffuse and hard to treat. Here again he used hot water, bismuth, and tar, the latter, usually diluted, being applied only after removal of the infiltration by the hot water. The preparation of tar which he wished especially to recommend was one prepared from wood-tar, mixed with methylic alcohol, and a most eligible preparation, as it does not stain the skin, washes off readily, and is pleasant to use. It can be diluted with water or oil. He was accustomed to use it diluted at first, afterwards increasing its strength, the skin gradually becoming accustomed to its use. It should be applied at night and washed off in the morning.

The line of treatment which he had thus sketched out was that which he now used exclusively, after having run the gauntlet of all the other remedies and measures which have been so much vaunted in this disease, and was convinced that it was the best.

DR. SHERWELL desired to protest against the complete neglect of ointments which marked Dr. Weisse's plan of treatment. He himself frequently used them, particularly cold cream with a little zinc ointment, the latter of much less than full strength, and had found them of great value. He had also used hot water and powders, the latter usually when treating a weeping surface. He liked the effects of bismuth for this purpose, particularly when mixed with calomel, one part of the latter to five or six of the former. He thought that this addition helped the process of resorption which should be set up in the part. Watery and alkaline lotions and emulsion of bitter almonds he also thought well of. He often used the oil of cade when the disease was in the scaly stage, and could not recall a failure from its employment. Arsenic he thought sometimes of service, particularly in malarial complications of the disease. He always associated the eczemas of old people, as it occurs around the feet, nates, hands, and neck, and over the extensor surfaces, with tendencies to rheumatism and suboxydation. In such cases, he did not use alkalies, but acids, preferably the nitro-muriatic, combined with tonics. Small doses of colchicum (℥ v.) he had often found to relieve sub-acid conditions of the system, which lead to the formation of uric acid, etc.

DR. PIFFARD said that he agreed with Dr. Weisse in his remarks concerning malnutrition, if he meant bad nutrition by the term. In eczema, nutrition was often rather in excess than the reverse. He had made careful examinations of the breast milk in some cases of infantile eczema a number of years ago, and had found a marked diminution of the fatty portion. This deficiency should, of course, be supplied. He often used alkalies in eczema, preferring the benzoate of lithium to all others. He had used liquor potassæ, but not with lemon juice, because given in that way it would become citrate of potassium. He thought hot water a valuable agent.

He used ointments, as a rule, even in moist eczemas. The mildest of all was simple mutton tallow, but he had seen cases in which no ointment was well borne. He had recently begun to use two valuable agents which had not been alluded to. The first was tar (or oleum Rusci) dissolved in turpentine (one part

to four), and filtered. This was an admirable application in infiltrated dry pruriginous eczema. The second means was scarification, which he had found of great value in subacute infiltrated eczema.

DR. TAYLOR thought that Dr. Weisse had given undue prominence to defective nutrition in the etiology of the disease, to the utter exclusion of local causes. He could indorse all that had been said about the use of hot water in eczema about the scrotum and legs, but thought it only an auxiliary, requiring the assistance of other agents. He had tried it in eczema of the fingers, where the disease is usually of a vesicular nature, but had found that it did harm. He had obtained better results from black wash (which he considered an admirable remedy), calamine or bismuth lotions, or the old lead and opium wash. After the acute symptoms had passed away, a good remedy was the liquor picis alkalinus. He had also used and could speak highly of turpentine, oil of cade, and tar. Solutions of caustic potash were also very serviceable in old eczemas of the legs.

DR. MORROW said that he rarely used hot water in infantile eczema, because it usually occurs on the face and scalp, where the agent might prove injurious. He believed in using ointments in almost all stages of eczema after the exudative had been passed, the true principle of treatment being to protect the diseased surface. Bismuth he had found to have a tendency to cake, and become a source of irritation. He thought the benzoated oxide of zinc the most universally applicable of all ointments. He also relied a great deal on the use of cholagogues, podophyllin, irisin, etc. In acute eczema, he had found local treatment usually efficient, but in all cases alkaline diuretics and depurative remedies, which act vigorously on the liver and intestines, were of great service. The more his experience widened, the greater became his faith in constitutional remedies in eczema. In eczema of the fingers, he thought oil of cade and zinc ointment the best local remedies, but thought the former a very treacherous agent. He described a case recently under observation in which one application of a weak ointment of this kind to the fingers had in a few hours caused an intense erysipelatous inflammation which extended above the elbow and persisted for a week.

DR. DENSLOW did not agree with Dr. Weisse as to malnutrition as a factor in the etiology of infantile eczema, the majority of the cases that he had seen being in robust, otherwise healthy, children. In his opinion, the principal cause of infantile eczema was the non-assimilation of fat, and he attached great importance to treatment of the intestinal tract to fit it for absorption of this article, particularly cod-liver oil. He was accustomed to use gray powder in gr. $\frac{1}{2}$ doses three times a day for a time, and afterwards cod-liver oil in liberal quantities.

DR. BROXSON said that, although he did not believe that the fact that eczema often improved under internal treatment, proved that the disease was of internal origin, he would not disregard internal treatment as an adjuvant. As to local treatment, he always kept two elements in view, viz., the removal of pathological products, and furnishing a suitable protective to the parts. By this plan, the majority of cases could be cured. The successful treatment of this disease required the exhibition of art, often in as many ways as painting a good picture. He had lately, on the recommendation of Unna, been using sulphur in the form of ointment (Unguent. sulphuris, \mathfrak{z} ss.; unguent. zinci oxid., \mathfrak{z} iss.) with good results. He could confirm what had been said concerning the treacherous nature of tar as a remedy, and the care required in its use.

DR. WEISSE, in closing the discussion, said that he had not intended to undervalue internal treatment in his remarks, and would gladly testify to the value of the depurative treatment mentioned by Drs. Morrow and Denslow. He had desired to speak only of the cardinal points of treatment which he followed, and not to cover the whole ground. As regards the uncertainty of the action of tar spoken of, he claimed that the preparation which he had recommended was free from this objection if used diluted at first.

DR. MORROW exhibited a case of

MULTIPLE FIBROMATA.

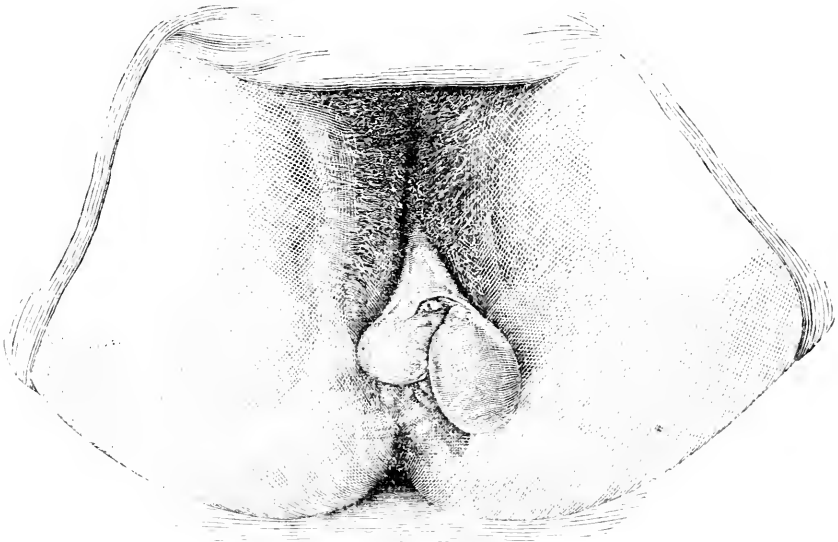
The patient, a woman twenty-two years of age, had had the disease six years. In the back hair and extending down upon the neck is a cluster of three flabby

pendulous masses, the largest, about the size of an orange, above, falling down over the two lower ones. This mass has been twice operated upon before. On the dorsal aspect of the ungual phalanx of the left thumb is a mass about the size of a hickory nut, of a flabby consistence, not very sharply defined nor lobulated. In the left popliteal space is a similar, smaller mass, and there is a small number of other tumors about the size of a coffee grain scattered over the skin of the chest and back.

DR. TAYLOR exhibited photographs of a case of

HYPERTROPHY OF THE LABIA MINORA

in a woman, twenty-five years of age. The patient contracted syphilis three years ago, and now has a fading syphilitic eruption upon her body. A short time ago, she came under treatment for gonorrhoea and chancroids. On examination, the labia minora were found enlarged, the left one enormously so, and at its base was a chancroid.



Dr. Taylor said that he explained the causes of the pathological process which had gone on in this case as follows: 1st, traumatism, from a kick received six months ago; 2d, infection with chancroidal virus; and 3d, hardening from the syphilitic process, of parts undoubtedly originally larger than usual. The tumor on the left side was at first as hard as cartilage, but is now growing softer under the use of mercury.

CHROMIC ACID IN AFFECTIONS OF THE TONGUE.—Mr. Butlin (*Practitioner*, March, 1883) recommends a ten-grain solution of the acid in cases of chronic superficial glossitis, and in ulcerative affections, including those of syphilitic origin.

Selections.

BUCCAL LEUCOPLASIA.

THIS disease has been also known under the incorrect titles of *buccal psoriasis* and *ichthyosis of the tongue*, and by Devergie was denominated *plaques blanches de la langue*, of which the name proposed by Schwimmer, *leukoplakia buccalis*, is only a translation. It is a chronic affection of the dorsal surface of the tongue and of the inside of the cheeks and lips, characterized by the formation of fine white scales and by a superficial induration of the mucous membrane, which is often fissured and ulcerated.

It is in general connected with a constitutional predisposition, and occurs sometimes in syphilitic subjects, especially such as have had buccal syphilides, and in whom the mucous membrane has hence acquired a peculiar susceptibility.

Buccal leucoplasia, whether its exciting cause be the irritating action of tobacco, or whether, as is sometimes the case, it can be traced to no exciting cause whatever, commences with an eruption of small, round, erythematous patches, at first of a red color, afterwards whitish and covered with a fine bran-like scurf. Upon these patches the papillæ are crowded together and become flattened out. The patches increase in size, and the character of their desquamation speedily changes. After the lapse of several months, or, it may be, of years, there are to be seen large spots, usually of a pearly whiteness, similar to those which are caused by touching the skin with the solid nitrate of silver. These can be removed in layers of varying thickness, and measuring from one to three centimetres in length.

In cases of still longer duration, ulcers form upon the desquamating places, which afterwards cicatrize and are covered with new epithelial growths; or the tense and hardened surface of the tongue becomes cracked and fissured in different directions. Later on, when almost the whole dorsum of the tongue is affected, the organ assumes a papillomatous aspect, being covered with small, pointed, conical, and horny projections, rough to the touch, like the tongue of a cat, and capable of detachment. This may be called the second or papillomatous stage of leukoplasia, which immediately precedes its transition into epithelioma. The above changes are generally confined to the dorsal surface of the tongue (extending to its edges and tip, and sometimes even involving the calciform papillæ of the lingual V.) and the inside of the cheeks and lips, in this respect bearing a strong resemblance to the smoker's disease, with which it has sometimes been confounded. A few white patches are occasionally found also upon the palate and gums.

As the disease advances, the functions of the tongue are soon interfered with. At first no inconvenience is experienced, but, as the desquamation increases, the tongue becomes stiff, and its mucous membrane is found to be indurated. This impedes the movements of the organ in speech, in mastication, and especially, after it has become fissured and ulcerated, in deglutition. An abundant and constant salivation now sets in. The contact of acids and the lodgment of particles of food within the fissures are causes of annoyance and sometimes of pain.

The complaint may persist during long periods—even fifteen or twenty years

—without advancing beyond the initial stage, and then may pass suddenly into the papillomatous condition. But in at least one-half the cases where this transition occurs, the objective characteristics of epithelioma will be more plainly manifested. A deeper-seated and nodose induration will then be perceived at the edge of the tongue, on one side only. The affected parts become more sensitive to contact, and darting pains extend even into the neighborhood of the ear. This last symptom is an important and invariable sign of epithelioma. Ganglionic engorgement then takes place, followed by the symptoms of constitutional infection.

In some cases the disease terminates in spontaneous recovery, after the lapse of one, two, or three years. Cures by art are rarely effected.

The *etiology* of leukoplasmia is imperfectly understood. It is confined entirely to adults, and is rarely met with in women. Its exciting causes are tobacco, various local irritants, highly seasoned articles of food, and alcoholic liquors. Mercury and iodide of potassium aggravate it in a degree proportioned to the progress it has made—hastening the advent of epithelioma in the papillomatous stage, and exerting a still more injurious effect when the former condition has become confirmed. An arthritic diathesis unquestionably acts as a predisposing cause. Almost all cases have a previous history of rheumatism, gout, or gravel—a fact which tends to corroborate Professor Verneuil's opinion that "epithelioma in general is merely a form, a product, of arthritis." Hereditary descent seems to bear no part directly in the development of leukoplasmia, but the same cannot be said of consanguinity, since the disease has been known to occur in several members of the same family.

Prognosis, in a complaint so refractory to treatment and terminating so often in epithelioma, must be guardedly pronounced. The patient's prospects are dubious in proportion to his advance in age. After fifty, the progress of the disease will be more rapid.

The most difficult question in connection with buccal leukoplasmia is its *differential diagnosis*. When the characteristic thick white patches are seen scattered over a glazed and reddened tongue in an individual free from constitutional taint and not addicted to tobacco, the true nature of the disorder is comparatively easy of recognition. But it is quite otherwise when the subject is a smoker or is syphilitic.

The distinguishing signs may be thus stated: In syphilis—*i. e.*, syphiloma *en nappe superficielle*—the surface of the tongue is mapped out by fissures more or less deep, and imparting to it a knobby and lobulated appearance not encountered in buccal leukoplasmia. In syphilis, moreover, the desquamation is slight and firmly adherent, while in leukoplasmia it is abundant and capable, at a certain stage, of being removed by layers. Leukoplasmia affects the tongue on its dorsal surface almost exclusively; syphilis, on the other hand, prefers the tip and edges of the organ, causing them to assume a notched and jagged appearance, and sometimes even attacks its under surface. The disease to which smokers are liable is less easily differentiated. This consists in a slow, chronic irritation of the buccal mucous membrane, causing an eruption of whitish patches on the inside of the cheeks and labial commissures and on the tongue. The diagnostic criterion in such a case is applied by cutting off the sources of irritation. If the patient is made to give up the use of tobacco, alcohol, spices, and similar injurious agents, an amendment will be perceived after the lapse of several weeks, or, it may be, a few months. In like manner, when syphilis lies at the root of the evil, a course of specific medication—preferably injections of peptones of ammoniate of mercury—will bring about a speedy improvement. In leukoplasmia,

on the contrary, mercurial treatment only aggravates, and abstinence from tobacco effects no perceptible change.

But the most difficult problem here to be considered is that which is offered when the effects of syphilis are combined with the local irritation produced by the abuse of tobacco. Its solution is best attempted by a process of successive elimination. Tobacco having first been prohibited, a course of mercury may be tried, unless the buccal affection has reached the papillomatous stage, in which case its effects will certainly be most injurious by stimulating the epithelial proliferations.

The treatment of leucoplasia should be both constitutional and local. From what has been said respecting its diathetic origin, it will be seen that anti-arthritic measures will be generally called for. These consist of alkaline preparations, Vichy water, etc. Topically, the use of emollient lotions has been found preferable to that of astringents. The smarting sensation may be delayed by gargling the mouth five or six times a day with an alcoholic solution of salicylic acid, forty drops to a glass of water. Caustic applications have been recommended, and the following is the prescription usually employed by the author:

Chromic acid (chemically pure)..... 1 gramme.

Distilled water 5 grammes.

This is applied to the protruded tongue by means of a camel's-hair brush, and then washed off with plenty of water. By this means not only may the fissures readily be healed, but the entire affection will often be ameliorated and sometimes brought to a stand. The acid nitrate of mercury was recommended for the same purpose by Devergie.

But, however favorable the results of these procedures may for a time appear to be, the hope of a complete cure must not be too confidently held out. Such a termination is exceptional, and after a few months, sometimes only a few weeks, the symptoms apparently vanquished will be likely to reappear. The longer the disease has lasted, the more marked will be this tendency to relapse.

In a long-standing case of leucoplasia, when papillomatous growths are present, or when such a condition is manifested by a patient already under treatment, the indications are the same as for a commencing nodule of epithelioma. Cauterization here is not to be thought of; it would only forward the malignant process. Prompt surgical interference can alone avail, the proper methods of which have been clearly laid down by Professors Trelet and Verneuil, in a very interesting discussion at the Société de Chirurgie, November and December, 1880.—VIDAL, *L'Union Médicale*, January 4, 1883.

ON LYMPHATIC COMPLICATIONS IN ECZEMATOUS DISEASES.

OUR observations have compelled us to admit that the engorgement of lymphatic glands takes place, as a rule without exception, in all varieties of eczema. We have ascertained, moreover, that eczema—both in its acute and chronic stage, whether appearing in the form of small, moist and ulcerated milium vesicles, or in that of large, dry, and whitish scales—whether occurring spontaneously or as the result of traumatism or of an irritating application, is always accompanied by adenitis, which constitutes its most usual complication.

As to lymphangitis, this we have only exceptionally met with as a complication of eczema; and hence, considering its rare occurrence, we have been led to examine whether, in such cases as we have had the opportunity to observe, the primary lesion was not associated with some foreign morbid element. We have

found in most instances that the lymphangitis either followed upon an irrational or empirical treatment of eczema, or appeared as the result of overwork or fatiguing journeys. Under such conditions, eczema acts as a predisposing cause. But assuredly the excessive exertion, the injuries, or the local irritant must be considered as the direct and immediate cause of the supervening inflammation.

It is under the same restrictions that we concede the existence of eczematous angioleucitis.

With regard to glandular abscess, it may be affirmed that eczema by itself never gives rise to this class of lymphatic complications, except in cases so extremely rare that we have met with only one of them that was clearly marked and well authenticated. Hence it is that whenever an eczematous adenitis reaches the stage of suppuration, we may conclude, with almost positive certainty, that the patient is scrofulous. It should be added that the lymphatic glands do not inflame and do not suppurate except in young children. The frequency of these occurrences in scrofulous children is easily explained. Eczema, simple or impetiginous, arouses to activity the pre-existing diathesis, and increases the tendency of the latter to manifest itself outwardly in the form of glandular affections. In these cases, therefore, we have two causes—*i. e.*, scrofula and skin disease—working in the same direction.

Having thus summarily indicated the nature and causes of the lesions which in eczema may attack the different departments of the lymphatic system, we will conclude with a reference to the anatomical changes underlying all these aggravations. It is no very difficult task to explain, on purely histological grounds, the mode in which eczema reacts upon the lymphatic system as a whole. Whether we believe, with one party, that eczema is a superficial disorder, involving the epidermis only, or, with another, that its seat is in the various layers of the derma, we must in either case conclude that both the superficial and deep-lying lymphatics of the skin are always implicated and often seriously affected in its progress. From this point to the propagation of the inflammation along the whole lymphatic canal, and ultimately to the gland itself, is but a single step, and that a very easy one. Both anatomical reasoning, therefore, and clinical evidence unite in demonstrating the possibility of lymphatic complications in eczematous affections.—ROLAND, *Th. de Paris*, 1882.

NAPHTHOL IN SKIN DISEASES.

DR. ENGELSTED, physician-in-chief to the department for cutaneous and venereal diseases of the City Hospital of Copenhagen, Denmark, in his report about this and some other hospitals under his care (Copenhagen, 1881, p. 125 seq.) mentions the results he has obtained by the compound ointment of naphthol recommended by Kaposi for scabies. It is composed of naphthol 15, adeps 100, sapo viridis 50, and creta alba 10, and was used for inunction morning and evening for two days. Engelsted has found it less reliable than linimentum styracis (balsami styracis liquidi 200, olei olivarum, alcohol, aa 50), linimentum Hebræ, or preparations of tar in general.

In psoriasis, he tried a 15-per-cent solution of naphthol (naphthol 45, alcohol 200, aqu. destil. 100). It may be applied both to the skin and to the scalp, and has the great advantage over tar remedies that it does not smell, and does not stain the linen. It is rubbed morning and evening on the scaly spots. After a few applications, the scales became more brittle and easier to detach, but in the majority of patients the irritation after four or five applications became so great that the treatment had to be discontinued. By the use of some mild ointment

and warm baths the irritation subsided, and a considerable diminution of the scale formation and the subjacent infiltration was then observed. After the end of a week, the applications were repeated four or six times, and in this way the remedy was used with intervals of a week or two, until the skin was free from scales and infiltration. Engelsted holds this solution of naphthol to be very valuable in the treatment of psoriasis, but yet the effect is by far not so sure and prompt as that of the ointment of chrysarobin, four or six inunctions (twice a day) with which have often sufficed to remove thick layers of scales and considerable infiltration. But this valuable remedy has the drawback that, applied to healthy parts of the skin, it leaves a very dirty color which may last for a week or two, and sometimes causes considerable irritation, for instance of the eyes. It is, therefore, very important to close up the rubbed surfaces very carefully.

Against itching skin diseases Engelsted has used a one-half-per-cent solution of naphthol (naphthol 1, alcohol, aqu. dest., ãã 100), which, in many cases where tar remedies were indicated, such as artificial prurigo, eczema squamosum, itching after the treatment for scabies, etc., both diminished the irritation and caused the cessation of the itching.—*Hospitals-Tidende*, 1882.

Correspondence.

DERMATOLOGY AND SYPHILOGRAPHY IN GREAT BRITAIN.

(*Special Correspondence.*)

It is the intention of the writer of these letters to furnish the readers of the JOURNAL OF CUTANEOUS AND VENEREAL DISEASES with a condensed account of the more important papers and communications on the above subjects which have made their appearance during the preceding three months; but he is conscious of some difficulty in the undertaking, as such of them as are brought before medical societies make their appearance in abstract only, the full paper not being published until the end of the year, when the various "transactions" are issued. It is, however, better to call attention to them at once, notwithstanding the necessary imperfection of a mere abstract, as the meetings of the societies reported in the weekly journals contain an account of the discussion which nearly always follows the reading of a paper, and which is not at present included in the annual volumes of transactions; but it should be borne in mind that the full paper only gives a complete account of the author's views, and should consequently be always referred to by students of the matter of which is treats.

An important paper by Mr. Jonathan Hutchinson, "On certain Diseases allied to Erysipelas" (*Med. Times and Gazette*, Jan. 6, 1883), is characterized by the great originality of view and wide grasp which distinguish all that comes from his pen. After calling attention to the fact that erysipelas may be often wanting in vesication, in abrupt margin, and even in hyperæmia, he defines as erysipelatous any inflammation which travels and is attended by œdema. He considers this allied to catarrhal inflammation, both being due to cold, with the difference that this latter is indirect, the part chilled not being the part attacked, while erysipelatous inflammation is direct, the part exposed to cold being also the part attacked. In recurrent attacks of erysipelas, the first is always the most

severe, but he has seen many cases in which recurring attacks on the face have led to elephantoid hypertrophy (solid œdema) of the eyelids and cheeks, and indeed thinks that elephantiasis is in the main a result of chronic and recurring erysipelas. There are many instances of ladies with sensitive skins who get erythema of the face after exposure to cold winds, or even eczema, which, however, shows its alliance with erysipelas by a tendency to spontaneous disappearance. He has seen a case of a young woman, æt. 19, subject to recurring erysipelas of the face, with vesication, for three years; the face had become more or less œdematous, pitting on pressure over a resistant point. These attacks are most common on the face, but may also affect the tongue; exposure to a cold wind is the common exciting cause, but they sometimes result from sun-burn or strong fire-heat. He goes on to describe the peculiar affection of the hands called vesicating erythema, forms of erysipelas due to local irritation (as carbolic dressings), and notes that carbuncle, in the quantity of extension at its borders, shows one of the most characteristic signs of erysipelas, and may therefore be erysipelatous inflammation modified. Mr. Hutchinson concludes that there is a family of erysipelatoid affections rather than a single disease erysipelas, some closely, others remotely, connected with the typical complaint. They are all specialized forms of inflammation, due originally to local causes, characterized by conditions indicating implication of the lymph-spaces, and all showing a tendency to rapid change. In all a virus is probably produced, which enables the disease to spread by contagion, and whenever contagion to another person occurs, the disease is intensified: finally they are all milder and less contagious in successive attacks. In connection with this subject attention may be directed to two cases of idiopathic erysipelas in male infants a few weeks old which were both fatal. (Strugnell, *Brit. Med. Journ.*, Feb. 3, and Johnstone, *l. c.*, March 3.) Such cases are undoubtedly extremely rare.

Dr. Colecott Fox communicated to the Royal Medical and Chirurgical Society "Two Cases of so-called Erythema gangrenosum" on Jan. 9, which will be found reported in the weekly journals. He applied the term to cases belonging to the same category, but differing much in severity, and not all gangrenous. The first case was that of a lady of intemperate habits, æt. 47, in whom gangrenous patches continued to evolve at intervals from 1877 to the present time. They were limited to the chest and arms and occurred over and over again about the site of former patches, being often roughly symmetrical. The patches were very frequent at first, but as the general health and habits improved became rarer. There was no ordinary sign of hysteria, but she had at one time an attack of paraplegia lasting about three months. In the second case a very hysterical girl of seventeen was the subject of severe inflammatory, vesicating, but not gangrenous patches for many months. They occurred with fair symmetry over the body and extremities, with a marked tendency to attack the sites of former lesions. In neither case was there sufficient cachexia to account for the severity of the lesions, and the surfaces healed fairly well; Dr. Fox therefore raised the question whether there exists such a thing as idiopathic erythema gangrenosum, or whether such cases are not invariably artificial. There were five cases on record where malingering was not actually proved, but they were all suspicious, as they occurred in young eccentric and hysteric females; there was an entire absence of any sufficient antecedent of gangrene, a healthy reparative process went on, and the patches were such as might be produced by caustic; in all particulars they differed greatly from genuine gangrenous affections (vaccinia and varicella gangrenosa). Finally numerous exactly similar cases were cited in which shamming

had been proved, from simple erythema by mustard and excoriations by rubbing, to gangrene by nitric and sulphuric acids. In the discussion Dr. Thin mentioned that such cases were considered genuine at Vienna by dermatologists, but not by surgeons. Mr. Savory said that some patients appeared to be spontaneously predisposed to gangrene from slight causes, but these were usually alcoholic. Dr. Buzzard had seen two cases, but was doubtful as to their genuine nature.

A remarkable "Epidemic of Herpetic Fever" is described by Dr. G. H. Savage (*Lancet*, Jan. 20). The outbreak occurred in a school in Surrey, and from November 13 to 27, 1882, thirty-nine boys were affected, of whom only nine were complete cases, *i. e.*, showed all the symptoms. The affection began with languor, headache, loss of appetite, and chilliness; then a rigor followed by vomiting, usually only once. On the first day the temperature was 102° to 104.8°, there was thirst and flushing with restlessness or delirium at night; no diarrhoea. Next morning there was slightly less fever, and patches of herpetic vesicles appeared about the lips or lobes of the ears; at the same time the throat was swollen, red, and sore; tongue moist and furred. On the third morning the herpetic clusters had matured; the throat was either dull-red and oedematous, or showed one or two probably herpetic spots; tongue cleaner, and never with prominent red papillæ. By the fourth morning there was normal temperature and convalescence; no relapses occurred and the lungs were normal. There was no similar epidemic in the neighborhood and no local cause was discovered, for at first nearly all the cases occurred in one large block, but all the later ones in a new isolated building. Those attending on the boys affected suffered more or less from a similar disorder. Great prostration followed in all the cases.

Mr. Richmond Leigh reports a case of "Bullous Eruption of peculiar Character" (*Lancet*, Jan. 6, p. 11), occurring in a female five days after parturition. The description corresponds entirely to a mild attack of pemphigus. The case of "Psoriasis of the Nails," published by Mr. Herbert Smith (*Brit. Med. Journ.*, March 3, p. 405), was pretty certainly eczema, as it was immediately preceded by a vesicular eruption on the palmar surface of the affected digit. A "Case of Purpura" by Dr. Napier (*Glasgow Med. Journ.*, February, p. 159) is of some interest. A girl *æt.* 14 after great fatigue suffered from severe pains in the limbs. The same evening there was slight fever, 100.2°, the legs were swollen and tense from the knee to the ankle, the swelling being firm and resistant, not pitting on pressure, and extremely tender; over the swollen parts there were numerous spots of purpura varying in size, from a pin's head to a sixpence; the joints, gums, and mucous membrane of the mouth were normal. Three days later the spots had faded to a bruise-color, but symmetrically placed painful circular swellings appeared on each parietal bone, and on both elbows were bruised-looking tender spots; the back of the right hand was swollen and tender, but not discolored. On the next day the back of the left hand became similarly affected, and in a few days more the whole attack had subsided. This was not simple nor rheumatic purpura, nor purpura urticans, and there was no scurvy. Dr. Napier considers it to have had a neurotic origin from over exhaustion, and the striking symmetry and acute circumscribed oedema undoubtedly lend support to this opinion.

In a valuable paper "On the Relationship of some Forms of Integumentary Atrophy" (*Edinburgh Med. Journ.*, January), Dr. Dyce Duckworth expresses his belief that a chain of relationship connects various local atrophies, from the simplest expression in pigmentary change, up to the gravest form met with in unilateral facial atrophy, the basis common to all being a tropho-neurosis. He accordingly arranges, in an ascending scale of intensity, the following affections:

Area, Canities, Leucopathia, Striae and Maculae atrophicae, Leioderma (Glossy Skin), Scleroderma and Morphea, and lastly Hemiatrophia facialis.

Among hypertrophic affections of the skin and its appendages there is none more remarkable than the curious condition called "Hypertrichosis universalis," of which a good example in a female child, aged about seven, has been recently exhibited in London (*Brit. Med. Journ.*, Jan. 6, p. 28). The child was brought from Burma, and is described as having the hair of the head jet-black and straight, the nose short and flattened, the cheeks fat, but otherwise normal. The milk dentition is present, many of the teeth being bad and small; the only permanent tooth being the first molar; the jaws do not project. The body is perfectly normal, the hands and feet well-formed, and the fingers very mobile. The hair of the head is continued down over the brow so as to be continuous with the eyebrows, and is short across the centre of the forehead, increasing in length towards the eyebrows; it is prolonged downwards on the sides of the face in front of the ears, forming well-marked whiskers; on the greater part of the face there is more or less hair, which is most copious where it occurs normally in adult males. Over the body there is soft straight hair, not so thick as to hide the skin; it is increased around the vulva, but not upwards to the umbilicus; on the forearms the hair is directed outwards and upwards, on the upper arms downwards and outwards. It is quite possible that such cases are to be regarded not as true hypertrophies, but rather as examples of "atavism": i. e., more or less complete reversions to the original hairy type from which the race of man most probably started.

Surgeon-Major Peters, writing "On the Treatment of Leprosy" (*Edinburgh Med. Journ.*, March, p. 809), gives the results of two years' experience, at a leper asylum in India, and details shortly twenty-nine cases which were all much improved by the following plan: the patient early in the morning had to rub in carbolic oil (1 to 40) all over the body for two hours, and then bathe in warm soap and water; afterwards an emulsion of gurgun oil (1 part of the oil to 3 of lime-water, well mixed so as to form a thin creamy ointment) was rubbed into the affected parts only, any ulcerations being filled with cotton-wool smeared with the emulsion. Under this treatment the ulcers healed rapidly, but the anesthetic parts and nodules remained unchanged; these, however, were much benefited by inunction of cashew-nut oil, rubbed in so as to produce repeated blistering. Internally a mixture was given of chaulmoogra oil \mathfrak{m} v., with sodæ bicarb. gr. v., aq. menthae pip. \mathfrak{z} i. t. d., pot. iod. being employed only in concomitant syphilis. Dr. Peters notes that two of his patients (a Brahman and a Buddhist) were strict vegetarians, in whom, of course, an improper fish diet could not have caused the disease.

In the departement of syphilography there is not much to note. Dr. Bernard (*Liverpool Medico-Chir. Journ.*, January, p. 25) has examined "The Site of the initial Manifestation of Syphilis in the male genital Organ" by an analysis of one hundred and twenty cases of chancre; he finds that it appears most frequently on the inner surface of the prepuce (fifty-three cases) and least in the urethra (one case only). A remarkable case of "Extensive Diffusion of Syphilis by a Midwife" (*Brit. Med. Journ.*, Feb. 17, p. 335) has recently occurred at Sheffield. The woman had syphilis of the finger, and although she knew the nature of her complaint, and had been repeatedly warned to give up her business, she continued to attend cases of labor, and no less than forty-five persons were directly or indirectly infected through her instrumentality. She was prosecuted by the corporation of Sheffield, and the facts having been proved to the satisfaction of a jury,

was sentenced to twelve months hard labor, by no means too severe a punishment. Although, perhaps, not strictly within the scope of this journal, attention may be directed to an "Abstract of a clinical Lecture on syphilitic Gumma of the Pharynx" by R. Clement Lucas (*Practitioner*, February, p. 115) and to a paper on "Gummata of the Scelerotic" by C. Higgins (*Brit. Med. Journ.*, Feb. 10, p. 247). Both are good accounts of important and rare late manifestations of syphilis.

LONDON.

CAVAFY.

Reviews.

TRANSACTIONS OF THE AMERICAN DERMATOLOGICAL ASSOCIATION, at the Sixth Annual Meeting, held at Newport, R. I., Aug. 30 and 31, and Sept. 1, 1882. Official Report of the Proceedings by the Secretary DR. ARTHUR VAN HARLINGEN. Chicago, 1883, pp. 72.

THE recent meeting of the Association whose proceedings are before us was well attended and was one of the most interesting that has thus far been held. The titles of the papers read on that occasion have been already given in this JOURNAL, and several of the papers have appeared in full in its columns. The report before us, we regret to say, is the most carelessly prepared and most inaccurate report of a scientific body that has ever fallen under our notice. In justice to the Secretary, it should be stated that he was not personally present at the meeting, but has apparently left the preparation of the report to the reporter engaged for the occasion. A portion of the report fell under our eyes when published in the *Chicago Medical Journal*, last fall, and attention was called to the inaccuracies contained in it. These, we find, have in the main been corrected in the version before us. The proceedings of the second and third days we have now seen for the first time. As evidence of the careless manner in which the discussions have been reported we give a few extracts, together with the necessary corrections. On page 50, we find the sentence—"This occurred sixteen years ago—since then only two cases" (of leprosy) "have been observed in the entire State of New York." The statement actually made was that there were but two cases in which the *first symptoms* of leprosy had developed in the State. During the period named, more than twenty cases of the disease have been observed. On page 51, we find that (*italics our own*): "Dr. White *also believes* the statement of Dr. Fisher," etc. It should read: Dr. White *alluded to* the statement, etc. On page 56, "Dr. Denslow took the patient under his care," should read: Dr. Taylor took, etc. On the same page, the sentence—"but in cases where there was doubt whether it was *erythema nodosum* or *rosacea*," should read *eczema erythematosum* or *rosacea*. On the same page: "In psoriasis he had given it (*ergot*) because he had used a drug, *ustilago maidis*, in ichthyosis, a similar disease." The speaker actually said that he had *not* used it in psoriasis, but that Lombroso had used a similar drug, *ustilago maidis*, in ichthyosis. On page 62, "Dr. Piffard said that he preferred the *curetry*" (in warts of the hands). As a fact, Dr. P. has never used the cautery in this affection, and said that he was in the habit of using the *curette*. These are

but samples of the many erroneous statements that could be pointed out, and attention is now called to them lest the reader of the transactions might obtain the impression that the members of the Association were not in a condition to intelligently discuss the subjects before them. It is to be hoped that at the next meeting the services of a more careful reporter will be secured, and that the circulation of the present volume will be confined to the members of the Society.

Received.

Beschleunigte Heilung des Lichen ruber exsudativus durch subcutane Arseninjectionen. Von PROF. DR. HEINRICH KOEBNER. (Reprint.)

Heilung eines Falles von allgemeiner Sarcomatose der Haut durch subcutane Arseninjectionen. Von PROF. DR. HEINRICH KOEBNER. (Reprint.)

Two Cases of Myxedema. By DR. JOHN CAVAFY. (Reprint.)

Contribution à l'histoire naturelle de la Syphilis, etc. Par M. P. DIDAY. (Extract.)

Vaccination—Advice on the Necessity of Vaccination; the Value of Vaccination, etc. Issued gratuitously by the North Carolina Board of Health. Raleigh, 1882.

Il Rinoscleroma del Dott. CELSO PELLIZZARI. Firenze, 1883.

Transactions of the American Dermatological Association. Chicago, 1883. (Reprint.)

Etude sur le Condylome Anale par M. LERMOYEZ. (Reprint.)

Trattato Elementare delle Malattie Cutanee che osservansi in Italia; scritto dal PROF. GIUSEPPE PROFETA. Palermo, 1881.

Items.

CORN AND WART CURE.—GEZOC'S remedy for corns and warts is prepared as follows:

R Acid, salicylic.....	gr. xxx.
Ext. cannabis indic.....	gr. x.
Collodion.....	3 ss.

M.

LEPROSY IN NEW YORK.—There are four cases of leprosy in the dermatological wards of the Charity Hospital, besides two or three cases in other parts of the city.

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Original Communications.

TUBERCULAR SYPHILIDE OF THE EAR.

BY

SAMUEL SEXTON, M.D..

Aural Surgeon to the New York Eye and Ear Infirmary.

SYPHILITIC aural affections, if we include invasions of the middle, and perhaps also of the inner ear, are by no means rare, as a casual search of my own recorded observations shows. Bumstead and Taylor¹ state that "cases of syphilitic disease of the ear, or those recognized as such, are rare;" they say, however, that the external ear "is not unfrequently the seat of secondary manifestations." The only allusion to the invasion of the auricle by the tubercular syphilide that I find in this exhaustive treatise is, that in two cases observed by the authors where extensive eruptions occurred on the body and face, "the lobules of the ears were destroyed."² Unless the sound-transmitting or the perceptive structures of the organ of hearing be at the same time affected with this, or other disease, the otologist is not often afforded an opportunity of observing cases of syphilis affecting the external ear, since diseases of this portion of the ear do not give rise to deafness and are, therefore, more liable to fall into the hands of the syphilologist.

The following three cases of tubercular syphiloderm, which were sent to me for treatment, seem, on account of their rarity, to be worthy of a place in the *JOURNAL OF CUTANEOUS AND VENEREAL DISEASES*.

For the reports of the two cases first given below I am indebted to my

¹ *Venerereal Diseases*, p. 729. Phila., 1879.

² *Loc. cit.*, p. 546.

late assistant, Dr. Adolph Rupp, without whose interest in the treatment and recording of these cases in the hurry of a large clinical practice I should be unable to present them so satisfactorily.

CASE I.—Female: K. T.: born in U. S., but of Irish parentage. Her age is twenty-seven years and she is married. She came to my aural clinic at the New York Eye and Ear Infirmary May 8th, 1882. The patient was a dark blonde; her face had a dusky, flushed appearance, and the nose looked thick and red—conditions which the patient attributed to having a cold in the head, which was contracted two months previously, at which time she also suffered much from headache.

She stated that a month ago her ears began to itch a great deal, and the druggist to whom she applied for relief gave her a "wash" which she says "burned" her ears and gave rise to the ulcers on her auricles, for the cure of which she now applies. She complains of severe headache which radiates into the face, and of the running from the nose.

The ulcerations on the auricles, having an appearance which suggested their syphilitic origin, a history of the case was inquired after. Syphilis was denied, she stated, however, that her husband had been treated at Bellevue Hospital for some genital trouble.¹



FIG. 1.

Examination of the ears shows that the superior portion of both auricles (see Fig. 1) was the seat of an eroding ulcer, covered in part with dirty, thick, dark crusts, emitting a disagreeable odor. On the right ear the ulcerative process involved the anterior portion of the auricle, the tragus, and the anti-tragus, including the intervening parts, and a part of the lobule. Ulceration of these parts of the auricle is less

¹ Inquiry at Bellevue Hospital elicited the fact that her husband had been operated on for perineal abscess and urethral stricture.

marked on the left side. The auricles are both of them infiltrated, especially so in the immediate vicinity of the ulcerations. The unseemliness of the ears was very marked, the crusts on the right ear being particularly conspicuous. The diagnosis of tubercular syphiloderma was made and was subsequently confirmed by Dr. L. D. Bulkley, to whose clinic the patient was sent for examination.

Treatment. The patient was put on the mixed treatment of bichloride of mercury and the iodide of potassium in very small doses. No local medication whatever was recommended.

May 15. Pains in the head and elsewhere no longer remain. Her nose feels better; the coryza is much less. The nose had been examined for ulcerations, but none were found. The appetite has improved. Her face is still flushed and dusky in appearance. The lips and mucous lining of the mouth are pale. The ulcerations on the auricles look cleaner, and the redness and infiltration are somewhat diminished. The entrances to the canals are more free in consequence of the clearing away of the incrustations. Treatment continued.

May 18. The large crust which covered the region about the tragus has fallen off, leaving only the base of the right tragus. Crusts have fallen off from other parts of both of the auricles which were the seats of ulceration, leaving clean ulcers, with sharply defined irregular edges, and a show of tissue loss. The red and infiltrated condition of the auricles has almost entirely disappeared, but the deformity from ulcerative action, and probably also from atrophy, is quite perceptible. The patient was feeling very well in all respects, and did not again return to the clinic after this date.

During the course of treatment the patient confessed to having once had the same kind of eruption on her arms that was then seated on the auricles, but it had some time previously disappeared and when she came under observation there was no other eruption on any portion of the body. An interesting feature of this case was the rapid improvement under very small doses of the biniodide of mercury and iodide of potassium—about one-fortieth of a grain of the former and two and a half grains of the latter being given three or four times daily. The prompt effect of the medicine was probably owing to the fact that the patient had not been previously treated with these remedies. She seemed to have had no idea of the gravity of the affection and was only distressed on account of the disagreeable odor emanating from the sores and their unsightliness.

CASE II.—Female, thirty-two years of age, of German nativity. This patient was referred to my aural clinic at the New York Eye and Ear Infirmary by Dr. H. G. Piffard. The usual inquiries pointing to the aural history of the case elicited the statement that when seven years old she had measles which left her with a discharge from the right ear, lasting until she was seventeen years old and discharging occasionally since then. Seven years ago she had peritonitis. She comes to the clinic on account of the unsightly incrustations on the right auricle. The right ear discharges slightly now. She complains much of headache which is probably in part due to obstipation. Over two years ago she contracted syphilis from her husband—at first there was a sore on the vulva which healed

readily. There was very little subsequent eruption, and her hair came away to a slight extent only. She had been immediately treated with mercurials. Over the right frontal prominence there is an immovable hard swelling with a base of the size of a five-cent piece—this gives rise to pain which is worse at night.

Aural examination showed that the antitragus, tragus, and a portion of the concha of the right ear were covered, to the extent of about three-fourths of an inch in diameter, with a thick dark crust, its perpendicular diameter being greatest. Some rather inspissated pus was seen lying deep down in the canal—the result of the chronic purulent inflammation of the middle ear. A diagnosis of tubercular syphilide of the auricle was made and the patient was placed on the following:

R Hydr. bichlor..... gr. i.
Potas. iod..... ʒ ij.
Aque dest..... ʒ iv.

M. Dose, a teaspoonful three times a day.

Aug. 24. Auricular incrustations have diminished in size considerably. The right ala nasi is red and infiltrated.

Aug. 31. The incrustated part of the right auricle is much smaller; no longer extends into the canal. The parts are now dry. The swelling on the forehead is about one-half the original size, and is not yet free of pain. The treatment to be continued.

Sept. 7. Crust nearly all gone from the auricle. Treatment the same.

Sept. 14. The node over right frontal protuberance is gone, but the pains there have increased. The crusts on the right auricle have nearly disappeared.

R Hydg. bichlor..... gr. i.
Pot. iodi..... ʒ ij.
Aqua dest..... ʒ iv.

M. Dose, a teaspoonful three times a day.

Nov. 9. The right auricle feels hot to her; is red, and in places moist and scabby, and the lobule is infiltrated. The stomach seems to be disturbed by the medicine. The appearance of the auricle is eczematous, and the viola tricolor (fluid ext.) was ordered to be taken every four hours in doses of thirty drops in half a glassful of water.

Nov. 13. Auricle less humid. A swollen gland can be felt beneath lobule. The improvement is marked.

Nov. 16. Lobule less infiltrated, but the crusting over it and parts of the auricle is greater.

R Hydg. ox. rub..... grs. ʒ.
Viola tricolor, fl. ext..... ʒ vi.
Aque dest..... ʒ iv.

M. Dose, a teaspoonful every four hours.

There was subsequently a weeping eczema in the groove between the helices; the surface was red, with small, almost military vesicles. There was also a similar condition of things at the insertion of the auricle posteriorly. Her last visit at the Infirmary was on March 8, 1883, at which time this eruption in the auricle was all that troubled her; there was little or no otorrhœa.

This case, although less marked as a syphilide, seems to possess much interest for the syphilologist in consequence of the apparent influence of

the intercurrent invasion of eczema during its course. *After the dropping off of the scabs had occurred, it was found that there had been scarcely any loss of tissue underneath.*

It appears, according to Bumstead and Taylor,¹ that "the course of syphilitic eruptions is not infrequently interrupted or even permanently arrested by some acute disease." Numerous instances of this have been reported, the influence of erysipelas being most frequently observed, according to French authorities. I have not been able to find any reference in the work cited above to the influence of intercurrent eczema during the course of syphilides, although I dare say such an occurrence is by no means rare.



FIG. 2.

As soon as the mixed nature of the affection was manifest, the treatment was adapted to the new condition of things. The employment of the *viola tricolor* was decided on after reading an article on the subject by Dr. Piffard.² Its effect in this case seemed to be very considerable, but not so marked as in some other cases where the remedy was employed in the aural eczema of children.

The following case, although seen before either of the above, is introduced last, because it so well illustrates the deformity likely to ensue where a large portion of the auricle has been involved in the disease.

CASE III.—Mr. J. J., a shipping clerk, aged fifty years, consulted me in September, 1880, on account of otalgia in the right ear, due to carious teeth and a severe cold in the head contracted a week or so ago.

¹ Loc. cit., p. 513.

² The Medical Record, April 29, 1882.

The symptoms accompanying the middle-ear trouble of this case not being of any particular interest in this connection, will be omitted. It may be stated, however, that the patient had never had any aural trouble affecting the hearing before the present time, although when a child he suffered much from pains in both the teeth and ears.

In 1850, he contracted syphilis. His hair fell out, and he had sore throat and other syphilitic symptoms. On the face, head, body, and limbs rather dead-white, but well marked, cicatrices are seen. There are at present nodes on the right shin-bone. While under treatment, he was salivated, and then put on iodide of potassium, which drug he has been taking in larger or smaller doses ever since, discontinuing it at times altogether for a month or so. At present he is taking on his own account twenty-four grains of the salt three times a day.

Appearance of the affected ear.—The left (affected) auricle is, as shown in the cut (Fig. 2) very much deformed, the result of an ulcerative process. The cartilage seemed to be almost denuded, the skin covering it having a shiny cicatricial appearance. The thinness of the auricle is very well shown in the cut. The external auditory canal was naturally enormous in size on both sides. With direct solar illumination, one could look down upon and plainly see the *membranæ tympanorum*.

REMARKS.

It would seem that the tubercular syphilide is a tertiary lesion met with late in syphilis, that it is not liable to ulcerate, and that the loss of tissue when present is due to interstitial absorption. It is stated by Bumstead and Taylor,¹ that it is usually met with in cases that have not been thoroughly treated at the onset. It usually has a chronic course when the body is affected, is without pain, heat, or itching. When it appears late in the disease, the tubercles may be limited in number, at the time of eruption at least, and may be, as in the aural cases I have reported, confined to a single region. I have never seen a case of this disease early enough to observe its first symptoms. In the work above cited, the tubercles are said to "begin as deep-red spots, which slowly increase in size and thickness until, when fully developed, they have a diameter of from one-half an inch to an inch." Burnett² observed a case under the care of Duhring; he states that "the posterior part of the auricle is more likely to be attacked first than any other point, the spot most liable being the point of junction between the auricle and the head." In the case above cited, "there first appeared a circumscribed, infiltrated lump on the posterior surface of the auricle, which gradually increased until it has diffused itself throughout the tissues of the pinna." In my own experience, the disease seems disposed to confine itself to the anterior portion of the pinna.

The crust, as shown in Fig. 1, seems to be somewhat peculiar to some varieties of the disease. At first, it was quite adherent, with slightly

¹ Loc. cit., p. 544.

² Treatise on the Ear, pp. 232-233.

everted edges, which gave it the appearance of being much thicker than it really was.

Atrophy follows this eruption; but, unless tubercles have been permitted to long remain without treatment, cicatrices, if present, may not leave any marked deformity.

Should ulceration occur in any portion of the eruption, which it sometimes does, the thickness of the crust will be increased—the color becoming greenish-black, its surface rough—the resulting cicatrization leaving unsightly scars.

A careful consideration of the more apparent symptoms of this disease will leave but little doubt in the mind as to diagnosis when a case is under observation. There are certain cases, it is true, of eczema, lupus, epithelioma, etc., which resemble the tubercular syphilide; thus Buck¹ reports a case which he has diagnosed as an epithelioma, but which, from the local appearances described, might be taken for a tubercular syphilide.

THE TREATMENT OF ECZEMA.

BY

DR. McCALL ANDERSON.

(Continued from page 240.)

THE DIET is of great importance, and must be very carefully regulated, especially in the subjects of the rheumatic and gouty diatheses, and when the disease is associated with symptoms of digestive derangement. The patient should be warned to eat moderately and slowly, and to masticate his food well. In a few cases it will be found of advantage to prescribe very light or even milk diet, all animal food being avoided for a time—in those, namely, who are laboring under an acute attack, or who have been in the habit of indulging too freely in the pleasures of the table, for there can be no doubt that the eruption in quite a number of cases is called forth by excesses in diet, especially among the upper classes. When eczema occurs in diabetic subjects, the avoidance of saccharine and of amylaceous food (which in the system yields sugar) is generally necessary, as well as other treatment applicable to cases of diabetes occurring in those who are laboring under eczema. Quite recently, on the recommendation of Mr. Balmano Squire (*Brit. Med. Journal*, April, 1822, p. 499), a meat diet, even in non-diabetic persons, has been tried on the principle of Bantingism, and occasionally with the best results, although we have not yet sufficient experience to enable us to say exactly in what class of subjects it is likely to prove of service.

¹ Diagnosis and Treatment of Ear Diseases, p. 51, Wood's Library. New York, 1880.

In most other cases a simple mixed animal and vegetable diet may be recommended, oatmeal, fresh breadstuffs, soups containing vegetables, as broth and hotch-potch, cheese, strong tea and coffee, dressed dishes, pastry, pickles, spices, and articles of diet known by experience to disagree being avoided, while sweet things should be either omitted or taken very sparingly. The use of wines and malt liquors must in general be suspended, or only a little weak whiskey and water taken with meals, unless in scrofulous, debilitated, and anæmic subjects, where these may often be used more liberally with advantage; but we must beware of discontinuing them all at once in the case of those who have been in the habit for many years of taking them freely; and it must be remembered, with reference to prognosis, that the cure of an eczema is much more difficult when the patient has been addicted to the excessive use of stimulants. It is impossible to lay down rules applicable to every case, but it may be safely assumed that, whenever dyspeptic symptoms are present, the careful regulation of the diet is an important element in the treatment.

In this last class of cases in particular, as well as in gouty and rheumatic subjects, exercise in the open air is of the greatest importance, and horse exercise and joining in amusements of an active kind, such as shooting and golfing, are especially to be recommended; but in debilitated and anæmic persons, while they should be in the open air as much as possible, exercise should be in great moderation and short of fatigue, and we should be guided as to its extent and character more by its effect than by its amount.

LOCAL TREATMENT.—If, as I hope, the reader is convinced of the great benefit which accrues from the judicious selection of internal remedies in the treatment of eczema, and of their power, in many instances, of removing the eruption when administered alone, he will, perhaps, be hardly prepared for the statement which is made, as the result of a large experience, that the LOCAL treatment is in many cases even more effectual than the constitutional, although it must be confessed that the applications made use of by many practitioners are unfortunately too often ineffectual, and not unfrequently injurious.

The great success which attends the use of local applications is the less surprising if we bear in mind that some cases of eczema are local diseases throughout their whole course, being due to local irritation; and that many others, constitutional in their origin, owing to the constitutional taint which produced them, having subsided, are reduced at last to the category of local affections, our skins having the same tendency as ourselves to contract bad habits. Further, the mistake is too often made, not only by the public, but also by the profession, of supposing that applications to the skin have a mere local effect; whereas there can be no doubt that some of them, at all events, are to a considerable extent ab-

sorbed, act beneficially upon the system at large, and through it react upon the skin.

I shall not attempt a description of all the preparations in general use in the local treatment of eczema—some of them good, some useless, many hurtful—but shall give a short account of those which I have found most valuable, and, what is of the greatest importance, point out, as far as possible, the indications for their use.

Before doing so, however, it may be well to direct attention to the fact that there are a great many different ways of reaching the same goal, and also that a very common mistake which is committed is the too frequent change of remedies. As regards the last point, a very good general rule to lay down is, to persevere in the use of one kind of treatment as long as the case continues to improve. And to avoid disappointment, it must be mentioned that local applications are by no means uniform in their action, owing to the difference of sensibility of different skins, and for other reasons; hence, they sometimes aggravate the skin affection even when used in what appear to be appropriate cases.

The first point in the local treatment of every eczematous eruption, without exception almost, is to remove the crusts which have formed upon it. Till this is done, we can only guess at the condition of the parts beneath; our applications must, in consequence, be selected at random, and these cannot reach the diseased surface whose condition they are intended to mollify. One often meets with opposition on the part of the patient or friends in carrying this injunction into effect, either owing to their laziness, to their preconceived opinions, or to the pain which is sometimes experienced in the removal of the crusts. Patients come to me day after day, informing me that they have done what they could, but have only partially succeeded. The physician should in such instances repeat his instructions, and send his patient home again, and should refuse to prescribe any local applications unless those which are calculated to attain the desired end, till the diseased surface is fully exposed to view, by which means much less time is lost in the end, and the subsequent treatment is much more satisfactory.

The removal of the crusts is a very easy matter, and each practitioner has his own favorite method of procedure. I usually recommend the parts to be thoroughly saturated with oil, and the crusts, thus softened, are removed by washing with warm water, or, in the case of hairy parts, by combing. If this fails, a poultice composed of crumb of bread and hot almond oil may be applied to the eruption at night; and if the crusts do not come away with the poultice in the morning, the parts should be lubricated with fresh almond oil, and the crusts removed with the finger nail about half an hour afterwards, when they have become thoroughly softened. In many cases, the application of vulcanized India-rubber

dressings (which will treated of further on) is the most efficient means of removing them, especially when the head is attacked.

Supposing, now, that all the crusts have been removed, and the diseased surface fully exposed to view, what local applications are to be made use of ?

If the eruption has just made its appearance: if the surface is acutely inflamed: if it is the seat of a copious eruption of vesicles or pustules; if there is much swelling of the parts, or if burning heat is complained of in place of itching, we must exercise great circumspection as to the local treatment. In some cases every kind of local application is injurious, so that, if the above symptoms are well-marked, it is often better to avoid them altogether until the acute symptoms have in a measure subsided.

One of the safest methods of treatment is to dust the parts two or three times daily with an absorbent powder, such as powdered tale, starch, oxide of zinc, calamine (carbonate of zinc), lycopodium, carbonate of magnesia, violet powder, or Taylor's Cimolite (prepared white fuller's earth). The last is a fine and very scarce natural variety of steatite; it is found most abundantly in Spain, and is composed principally of silicate of magnesia. It is by far the best dusting powder which I have tried.¹ It is perfectly bland and unirritating, is in the finest state of subdivision, and has a smooth and oily feel, thus combining all the requisites for a perfect soothing powder. To any of these a little powdered camphor may be added to allay the burning heat. They may be combined in various ways, as undermentioned.²

A very good application is a cold potato-starch poultice, a small quantity of absorbent powder being sprinkled on its surface.

SOOTHING OINTMENTS are generally indicated in the acute stages of eczema, and are also of service with the view of softening and removing crusts and other debris. They not only act as sedatives, but also afford a covering for and protection to the inflamed parts, and exclude the air, but they require to be prepared with the utmost care and with perfectly

¹ Prepared by John Taylor, 13 Baker street, Portman Square, London, W.

² R Zinci oxidi,

Pulv. aluminis plumosi,

Pulv. rad. iridis floris..... āā ʒ i.

Pulv. amyli..... ʒ ij.

M. Sig. Dusting powder. (Hebra.)

R Camphoræ..... ʒ ss.

Sp. rectificati... q.s.

Pulv. talci,

Zinci oxidi..... āā ʒ ij.

M. Sig. Sprinkle a little over the part occasionally. Let a small quantity be made at a time, and let the powder be kept in a stoppered bottle, as it loses its strength by exposure to the air.

fresh ingredients; and even then, in a few persons, owing to some peculiar idiosyncrasy, they are apt to prove irritating, and cannot be tolerated, no matter what their composition may be. Fortunately, this is only observed in very exceptional cases.

A few of the more soothing ointments may now be mentioned. A very good application is a mixture of powdered oxide of zinc and glycerin, or almond oil, to which a little camphor may be added, if necessary, as follows:

R Pulv. camphoræ.....	3 ss.
Pulv. zinci oxidi.....	3 ij.
Glycerini.....	3 ij.
Adipis benzoati.....	3 i.
Cochinillini.....	gr. i.
Olei rosæ.....	℥i.

M.

One of the most favorite remedies in Britain is the “Unguentum oxidi zinci benzoatum” of Erasmus Wilson, Bell’s formula for which is as follows:

R Adipis preparati.....	℥ v.
Gummi benzoini pulveris.....	℥ i.
Liquefac, cum leni calore, per horas viginti quatuor, in vaso clauso; dein cola per linteam, et adde	
Oxidi zinci purificati.....	3 i.
Misce bene, et per linteam exprime.	

To this a drachm of rectified spirit, spirits of camphor, or Price’s glycerin may sometimes be added with advantage. The benzoin prevents the ointment from becoming rancid and irritating, while at the same time it imparts to it a certain fragrance. It is an excellent preparation, but, owing to the white crust which is apt to form, it is inferior to others when the eruption is situated upon uncovered or upon hairy parts. In such situations, the zinc ointment of Dr. L. D. Bulkley, of New York, is preferable, and is composed of pure carbonate of zinc and the ceratum galeni (cold cream), in the proportion of half a drachm to the ounce.

One of the most valuable of soothing ointments is the “Unguentum diachyli albi” of Hebra, of which the following is the formula:

R Olei oliv. opt.....	3 xv.
Lithargyri.....	3 ij. et 3 vi.
Coque l. a. in ung. moll., dein adde	
Ol. lavandulæ.....	3 ij.
M. Ft. unguentum.	

This ointment is likewise unsuitable for hairy parts, on account of its matting the hairs together. More recently several varieties of soothing ointments containing oleic acid have come into use, one of the best of which is the “Unguentum zinci oleatis,” recommended by Dr. Crocker, the formula for which is as follows:

R Zinci oxidi.....	i.
Acidi oleici.....	viii.
Vaselini.....	ix.

Rub up the oxide of zinc with the oleic acid, and let it stand for two hours; then place in a water-bath until the zinc is dissolved, add the vaseline, and stir until cold. Instead of this, Dr. Sawyer has more recently recommended an oleate of lead ointment, which is composed of lead oleate, twenty-four parts; heavy and inodorous paraffin oil, fourteen parts. The lead oleate is prepared by heating a mixture of oleic acid and oxide of lead, one part of the former to eight of the latter. It is prepared in the same way as the last ointment, but in my experience is inferior to it as a sedative application.

By far the best of all the soothing ointments with which I am acquainted, which was prepared at my suggestion by Messrs. Frazer & Green, chemists, Glasgow, and which is made in the same way as the oleate of zinc ointment, is composed of

R Bismuthi oxidi.....	i.
Acidi oleici.....	viii.
Ceræ albæ.....	ii.
Vaselini.....	ix.
Olei rosæ.....	iii.

I have not only used this ointment with the very best results myself, but those of my professional brethren to whom I have recommended it have professed themselves equally satisfied with it; and one medical man in particular recently informed me that it was the only ointment of the many which he had tried, which had proved a sedative in his own case.¹

¹ The *Medical Bulletin* of Philadelphia for July, 1882 (vol. iv., No. 7), contains an interesting paper by Dr. John V. Shoemaker on "The Oleates and Oleo-palmates in Skin Diseases." He recommends that the oleates of zinc, lead, and bismuth should be prepared in the following manner:

"Oleate of zinc is made by decomposing a sodium oleate with a saturated solution of zinc sulphate, boiling out and drying the precipitate and then reducing it to an impalpable powder, which is rapidly accomplished. One part thereof melted with three parts of a fatty vehicle yields the ointment I have been in the habit of using. I have, however, obtained the very best results with the oleate of zinc alone, and not mixed with a fatty diluent, which is a fine pearl-colored powder, with a soft-soapy feel, very much like powdered French chalk.

"Lead oleate is derived by precipitating a sodium oleate with a solution of lead sub-acetate. The washed and dried precipitate melted with equal parts of lard gives the ointment I designated as ointment of lead oleate.

"Bismuth oleate can only be obtained by first preparing a crystallized bismuth nitrate, dissolving this in glycerin, decomposing with this the sodium oleate. It is of ointment consistence, and should be used as thus obtained."

He is of opinion that the oleates possess the following advantages over ordinary ointments:

Instead of merely rubbing soothing ointments upon the inflamed surface, as is so often done, it is always preferable, when at all possible, to apply them spread thickly upon pieces of linen, which should not be too large, else they do not lie evenly upon the inflamed parts.

When the disease becomes chronic, as is indicated more particularly by the disappearance of the burning heat and the supervention of itching, the local applications which are appropriate are very different; but even they vary according to the stage of the eruption.

If there is INFILTRATION of the skin to any extent, the local treatment which I am in the habit of prescribing is that recommended by some Continental dermatologists—in connection with which the name of Hebra must always be honorably associated—and which has only of late come into general use. This is the treatment by means of POTASH applications, and which is often attended with great success. Having had the privilege many years ago of witnessing the carrying out of this means of cure in Hebra's wards at Vienna, some of the prescriptions may resemble very much, or even be identical with those of that distinguished dermatologist, though I am unable to state at this moment which are due to him and which are mere modifications of my own. I trust, however, that I have sufficiently done justice to his merits, and that I shall be acquitted of the desire of taking any credit except in so far as the success of this treatment was first thoroughly carried out in Scotland at the Glasgow Dispensary for Skin Diseases.

The strength of the local application varies with the amount of the infiltration, and likewise with the extent of the eruption; for of course, when the disease is extensive, it would be injudicious to make use of those very strong applications which may be applied with safety in the more circumscribed cases.

If the infiltration is slight, or the rash extensive, common POTASH SOAP (soft soap, black soap, *sapo mollis*, *sapo viridis*), or a solution of one part of it in two of boiling water, a little oil of rosemary or citronella being added to conceal in part the odor, may be used.¹ A piece of flannel dipped in this should be rubbed as firmly as possible over the affected parts night and morning, and the solution allowed to dry upon them, or a piece of flannel wrung out of the solution may be applied to the part and left in contact with it all night, if the patient can bear it.

“First, their deep penetration: secondly, their freedom from rancidity; thirdly, their cleanliness of application: fourthly, their great economy; and, fifthly, their antiseptic action.”

¹ B Saponis mollis.....	℥ i.
Aquæ bullientis.....	℥ ij.
Olei citronellæ....	℥ ss.

M.

A more elegant preparation is LIQUOR POTASSÆ, which may be painted over the eruption once daily with a large brush, its irritant properties being neutralized by means of tepid water if the smarting becomes excessive.

Instead of soft soap or liquor potassæ, solutions of POTASSA FUSA may be employed. In the mildest cases, with only slight infiltration, two grains of potassa fusa; in the more severe, five, ten, twenty, thirty grains, or even more in an ounce of water may be used, but we should rarely resort to a stronger solution where the eruption is extensive. Even the solution containing thirty grains to the ounce, which may be applied in the same way as liquor potassæ, must be used with great caution and soon washed off with water, and the application should not be repeated oftener than once daily at the most. When such a strong solution is prescribed, and especially if the eruption is extensive, it is advisable for the physician to apply it himself, at first, at all events; and in no case should it be used so strong, or allowed to remain on so long as to produce manifest destruction of the skin. When the eruption is very limited and very obstinate, and particularly when the patches assume the appearance represented by the terms *eczema sclerosum* and *verrucosum*, a much stronger solution may be applied, and Hebra sometimes used a solution of one drachm of potassa fusa in two drachms of water. "After the accumulated masses of dead epidermis in the form of scales, crusts, etc., have been removed by appropriate means, so as to expose the subjacent red, infiltrated moist surface, the solution is applied with a charpie brush, passed quickly and evenly backward and forward over the affected part in every direction; then the hand, or a piece of flannel, is to be dipped in water, and with it the lotion spread still more equally over the whole surface. A white froth, not unlike soapsuds, will soon be observed to form on the eczematous patch; and this only occurs when water is thus rubbed in after application of the caustic solution.

"When this part of the process has been thus finished, a considerable quantity of fluid exudes in drops upon the surface. To allay the pain, and to prevent the formation of scabs, rags dipped in cold water should be applied and frequently changed during the day. The patient need not be disturbed at night if care be taken that the rags are kept wet, and this is best done by help of oil-silk or gutta-percha. After water-dressing has been thus constantly applied for a week, the minute raw places of greater or less depth, which the caustic application has here and there produced, will have recovered their epidermis, and the itching, which had quite ceased during this time, will again become troublesome. Moreover, it will be soon observed that red spots re-appear here and there, and vesicles are seen; this should lead to a repetition of the former procedure. When the water dressing has entirely removed the traces of

the second caustic application, a third should follow, and this weekly course of treatment should be repeated as often as the symptoms just mentioned return. It is scarcely ever necessary for the solution of potash to be used more than twelve times, even in the most severe cases; for even if after this a few small places should show a disposition to relapse, some more gentle treatment will suffice to prevent it.¹

Instead of potassa fusa, some recommend solutions of chloride of zinc in similar proportions; but I have very little experience of it, being so well satisfied with the performances of the former. The following case, however, proves that it is a useful agent :

“ Hugh D., aged about 40, saddler, came to the Dispensary for Skin Diseases, Glasgow, March, 17, 1862. Small patches of eczema were noticed on the backs of his hands, sides of his fingers, and about his wrists. These were very itchy, with a good deal of infiltration, some of them studded with vesicles and exuding a serous fluid, others dry and scaly. Although some of the patches were situated over the joints of the fingers, there were no fissures. A solution of chloride of zinc (℥i. to the ℥i. of water) was ordered to be painted over the affected parts morning and evening, and if the action was too severe, it was to be moderated by the use of water.

“ March 24th.—Greatly improved; itching nearly gone; infiltration of skin much diminished; serous exudation very slight, and only after the application of the zinc lotion.

“ The patient noticed a slight tendency to the formation of new vesicles on and around the patches, which was at once checked, however, by the lotion.

“ March 31st.—Eruption gone.”

When any of these irritants are made use of they cause smarting, and when the stronger solutions are applied, often considerable pain; but patients have informed me that, although the smarting and pain are severe, they prefer it to their old enemy, the itching. On the other hand, some patients, although this is rarely the case, will not submit to a repetition of the remedy. I was particularly struck with this in the case of a medical man in Glasgow, who consulted me some time ago about an extensive eczematous eruption of old standing, and for whom I prescribed the mildest of the applications above referred to. He told a friend, shortly after, that he had applied it once, and that it had nearly killed him; the fact being that he had been affected with eczema so long, and had tried so many useless drugs, that his faith in the efficacy of remedies was shaken, and he would not give a fair trial to a system of treatment which, though a little unpleasant at first, would certainly have relieved him. But medical men are notoriously the worst and most refractory patients to deal with.

Having pointed out that the strength of the potash or zinc solutions

¹ “ On Diseases of the Skin, including the Exanthemata,” by Ferdinand Hebra, M.D., Sydenham Society translation, Vol. II., p. 152.

which are employed should vary with the amount of infiltration of the skin, it will probably have occurred to the reader that, when the eruption is extensive, and some of the patches much more infiltrated than others, a weak solution may be applied to the latter, a stronger one to the former; and it is equally obvious that, as the infiltration subsides, the solution may be gradually diluted.

Often, by continuing the use of a weak potash solution for some time after the infiltration is gone, all trace of the complaint disappears; but, in most instances, it is better to substitute for it one of the preparations about to be mentioned, as the disease verges upon a cure. But if, on changing the application, the infiltration of the skin reappears to any extent, it is better at once to have recourse to the potash solutions again. There is just one caution to be given before leaving this subject, namely, that care must be taken in the use of these solutions, and especially the stronger ones, in the case of infants, of delicate females, or of old and infirm persons, as the shock produced by their application might possibly be followed by serious results.

While these preparations are being employed, cold water forms a very agreeable and useful adjunct. The affected parts may be bathed with it, or it may be allowed to fall upon them from a height, with the aid of a watering can. Sometimes cloths wrung out of cold water may be placed upon the eruption with advantage in the intervals between the applications.

In every case, when practicable, soft water should be used; indeed, all persons with delicate skins should avoid hard water. If that which is at the disposal of the patient is hard, it should be boiled, so as to deposit a great portion of its salts; and then, as recommended by Hebra, it may be poured boiling upon bruised almonds or flour, or other mucilaginous substance, and used after it becomes cool. It is better still to make use of distilled or pure rain water. But in every case the constant use of water should be avoided as calculated to do harm instead of good.

It has been already pointed out that in mild cases the eruption is often kept up by the scratching alone, and that in these instances local sedatives have sometimes the effect of curing the disease by allaying the itching, and the desire to scratch the part. Hence it will be understood how, in more severe cases, while the scratching does not of itself keep up the disease, it tends to aggravate it, and to make it more rebellious.

We must therefore exhort the patient to refrain from scratching as much as possible, and at the same time we must employ means to allay the itching. The potash and zinc preparations have certainly this effect in a marked degree, and so has the application of cold water (for the time); but sedatives and narcotics taken internally are not, in my opinion, of the slightest service, except in so far as a large dose may produce sleep, and when the patient has long been deprived of it, owing to

the itching, this is much to be desired. Lotions of dilute HYDROCYANIC ACID, in proportions varying from ℥x. to ʒi. in an ounce of water, with the addition of a drachm of glycerin, may be applied with advantage whenever the part is itchy, instead of GIVING WAY TO THE DESIRE TO SCRATCH.

When such a strong solution as ʒi. of prussic acid to ʒi. of water is used, it must not be applied over a very extensive surface, and the patient must be warned that it is a very powerful poison. The potash solutions previously referred to are of the greatest service for the alleviation of the itching, as well as for the removal of the infiltration of the skin, so that it is often advantageous to combine the prussic acid with one of them, as in the accompanying prescription.¹

Some prefer the use of cyanide of potassium in the form of ointment. For this purpose from five to ten grains may be mixed with cold cream or the benzoated oxide of zinc ointment.²

In some cases, too, a pomade containing chloroform³ or a mixture of chloral and camphor⁴ is of service.

Although I have been in the habit of using the preparations of camphor principally with the view of allaying the burning heat in acute cases of eczema, I believe them to be equally serviceable for the purpose of moderating the itching in chronic ones.

But the most powerful remedies which we possess for the relief of itching, as well as for the removal of the disease, are the tarry preparations, which will be next considered.

(To be continued.)

- ¹ R Potassæ fusæ..... gr. v.
 Acid. hydrocyan. dil..... ʒij.
 Aquæ rosarum..... ʒi.

Sig. Sponge the parts night and morning, and when the itchy sensation is severe.

- ² R Cyanidi potassii..... gr. vi.
 Cerati Galeni (Paris codex)..... ʒi.
 Cochinillini..... gr. ¼.

M.

- ³ R Chloroformi ... ʒi.
 Adipis benzoati..... ʒij.
 Cochinillini..... gr. ¼.

M. Sig. Rub a little firmly over the parts which are itchy, but let none of the ointment remain undissolved upon the skin.

- ⁴ R Chloralis hydratis,
 Camphoræ..... āā gr. x.
 Misce intime, et adde
 Unguenti simplicis..... ʒi.

Sig. Apply when the parts are itchy.

NOTES ON LEUCODERMA.

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THE chief points of difference between albinos and persons affected with leucoderma are that the former have congenital inherited general deficiency of pigment of the skin and eyes, whilst the latter may have universal deficiency of pigment of the skin progressing gradually after puberty, but never deficient pigment of the eyes. Albinos are usually feeble and stunted, and prone to diseases of the chest;¹ leucodermic negroes are not noticeably enfeebled by the progress of the disease. I have had the opportunity of noticing a few cases of leucoderma in negro subjects for many years. In one case, which I shall presently describe, I was fortunate enough to get photographs covering a period of about twenty-three years; but so great is the superstition of the race that no inducement was sufficient to secure photographs of the others. From this series, three have been selected to show the march of the disease during six years.

Rhoda M., a negro woman, now aged about fifty-four years, was originally quite black, as shown by an ambrotype taken in 1861, and of pure negro parentage. About twenty-six years ago, she noticed the first white spots upon the backs of her hands. Her body next showed signs of the leucoderma; finally her hair, and then her face. She pursues the business of a midwife among the negroes; not possessing any skill in this line particularly, but having some air of mystery about her by reason of her unusual appearance, she turns it skilfully to account in securing patients. She is well nourished, and has good powers of endurance, except that at times a right carotid aneurism prevents her from doing hard work.

The first illustration is from a photograph taken in 1874. The almost exact symmetry of alphosis is shown here as in the other illustrations.

The course of the increase of the area of leucoderma was not steadily progressive, but in waves. This patient was examined at varying intervals, and the margin of pigmented patches carefully traced upon her photograph. It was discovered that the black patches would recede on one side, and increase upon the other; and especially upon the face the margins were not so abruptly black at all times, but fading into the white by imperceptible gradation. The increase of absorption rapidly advanced in the five years preceding this writing, until now she has more the appearance of a blonde white woman with black patches on her face.

¹ Duhring, *Dis. Skin*, 3d ed., p. 431.

The condition of the skin is very peculiar. To the casual observer, it appears much thinner than the skin of the negro, suggesting the idea of the obliteration of the rete mucosum. So highly sensitive is it that a moderate sun burns and the intense summer sun blisters it. The slightest scratch causes free bleeding, and nose-bleed is easily provoked, and recurs again and again. The nasal tract is exceedingly sensitive, and, as I have remarked in another place, does not bear out the theory of Mr. A. R. Wallace, that the deficiency of smell in some animals is due to the



FIG. 1.

absence of pigment there, for this patient has usual acuteness of this sense.

Six years after the first photograph was taken, I secured the second.

It will be observed that the leucodermic patches on the lips in 1880 were not so well marked as in this portrait of 1874, and that the patches around the eyes were not so distinct, and had really shifted their position. Alphosis of the trunk was very nearly completed. In the mean time, the sclerotic was deeply stained with a dirty brown pigment, but there was no other change in the eye.

Three years later, changes had come on very rapidly. She had in-

creased in rotundity of person, and her general health was very good. Her aneurism had increased somewhat in size; the skin presented the extremely delicate texture of an infant. Every little scratch was annoying on account of the considerable bleeding it occasioned.

The portrait here given shows beautifully the present stage of the disease. It was photographed in February, 1883. The entire body is bare of pigment except the nipples, and the distinctly black patches upon the face have more the appearance of being abnormal than the prevailing white.

No theory worthy of acceptance has been presented as to the cause of this disease. All we know of it is that it is always symmetrical in its progress. To say that it is due to faulty innervation hardly brings us



FIG. 2.



FIG. 3

nearer to a solution of the difficulty. The phenomena of pigment deposit and resorption are little known. Dermatitis will sometimes cause in the skin of the negro a stain deeper than that surrounding it, and it is sometimes lighter. This will depend, of course, upon the depth of the inflammation. But keloid, and scars from burns, are almost invariably several shades deeper than the healthy skin adjacent.

We have other examples of alphasia which may finally set us on the right path of discovering the origin of the centre which presides over it. I refer to the peculiar influence which syphilization sometimes has upon mulattoes. It is well known to those physicians who have watched syphilitic diseases among these people that the shade of their skin fre-

quently changes to several degrees lighter, and that this change is permanent and uniform over the whole body. The lack of complete analogy between this sort of alphosis and leucoderma, strictly so-called, is that the transformation does not occur in patches.

I reported a case some years ago (1876) in the *London Medical Examiner* of a very black negro who had leucoderma succeeding typhoid fever. He had no white patches previously. His business was that of a sawyer, and exposure to the rays of the sun upon newly sawed lumber became very painful to him. This man's hair did not turn white, nor did his skin become so sensitive, and there was not that abrupt demarcation between the white and black as in the case above reported. After several years of rapid alphosis, pigmentation began again, and I am able to reaffirm what I previously reported, that the process still continues. The skin is not becoming so black as natural, but the change has been repeatedly noticed by his friends.

These three types of alphosis may lead us in the future to a more correct study of the causes. 1. We have leucoderma in a woman who had no noticeable change in her health from beginning to end. 2. We have the entire skin changing several hues lighter after an attack of constitutional syphilis. 3. We have a leucoderma succeeding convalescence from typhoid fever, in which there is resorption of pigment, and a gradual redeposit. Are these all examples of a different disease? Or are they different manifestations, varying degrees of a process which has a central origin elsewhere than in the skin? No post-mortem examinations have been made of such cases, because they have only heretofore been medical curiosities. I think it is not impossible that an accumulation of knowledge may enable some one to solve the physiological problem of the central control of pigmentation, and in this spirit the study of such cases amounts to something more than the gratification of a love for the wonderful.

ALCOHOLIC PURPURA.

1. ALCOHOLISM alone will suffice as an exciting cause of purpura in predisposed individuals.

2. Pathologically considered, this form of purpura is due to changes brought about by alcohol in the blood, in the walls of the capillaries, and in the vasomotor system.

The precise manner, however, in which alcohol acts upon these elements has yet to be explained.

3. Alcoholic purpura runs a rapid course. While usually terminating favorably, it leaves a tendency to relapse.

4. Treatment should be directed, in general, to the functional troubles resulting from alcoholism, and specially, to the conditions which underlie the petechial eruption. The measures adapted to ordinary purpura are also those best indicated in these cases.—VOGELIN, *Th. de Paris*, 1882.

Society Transactions.

NEW YORK DERMATOLOGICAL SOCIETY.

136TH REGULAR MEETING, APRIL 24, 1883.

DR. E. B. BRONSON, *President, in the Chair.*

PRESENTATION OF CASES.

DR. MORROW exhibited a case of

PEMPHIGUS.

The patient was a boy six years old. The eruption first made its appearance about one year ago, and has persisted ever since, successive crops of bullæ continually appearing. The child's general health has suffered materially, and he is now much weakened and debilitated. When first seen, ten days ago, the greater portion of the body was covered with bullæ, varying in size from a pea to that of a cherry; around the ankles they were as large as a quarter of a dollar. The disease was most characteristically developed upon the anterior surface of the body, the inner surfaces of the thighs, and about the genitals, the lesions being more sparsely scattered over the remainder of the surface. The neck, face, and scalp are also the seat of the eruption. There are at present a number of bullæ on the penis, scrotum, and adjacent parts. No lesions are seen in the mouth, but the mother states that the boy often has "gum-boils," and is sometimes hoarse. The middle portion of the abdomen and the inner portions of the thighs are the seat of a diffused redness and thickening of the skin, showing papules in many places and presenting the appearances of an eczema. The remains of several large bullæ which have recently dried can be seen around the ankles. Pigmentation remains after the disappearance of the bullæ. Several enlarged glands can be felt in the neck and under the jaw, and the upper incisor teeth present a striking resemblance to those found in hereditary syphilis. The patient has been taking Fowler's solution of arsenic for the past ten days, and is now almost free from bullæ for the first time in eleven months. The mother states that the improvement began the second day after commencing the use of the medicine.

DR. ROBINSON said that he was much struck by the great number of bullæ which had been present in the case, and by the remarkable results of the treatment.

DR. SHERWELL remarked that he had three cases of pemphigus which he had treated with arsenic and linseed oil, two of which had entirely recovered. He could not say what had been the result in the third. He had exhibited before this Society a young girl ten years of age, who had one relapse, from which she promptly recovered, and has since remained perfectly well.

DR. MORROW said that the patient had had no other treatment but arsenic and a protective powder. When he first saw the case, there were at least two hundred bullæ on the patient's body, usually globular, but sometimes oblong, as if composed of confluent bullæ.

DR. FOX, in order to show that arsenic did not always have such a striking effect in pemphigus, alluded to two cases in which the bullæ continued to develop while the patients were fully under the constitutional effects of the drug.

DR. MORROW exhibited a

CASE FOR DIAGNOSIS.

The patient, a woman aged forty-five years, had her left breast removed about

two years and a half ago for what she was told was a fatty tumor. The wound healed readily, and she remained well until ten months ago, when an eruption appeared on the right breast and gradually spread over the entire chest and abdomen, and the lateral aspects of the trunk. The eruption on the right half of the body is almost diffuse, being composed of large numbers of small shining, red papules, suggestive of the papules of lichen planus, the entire skin being infiltrated and thickened. The lesions are larger, more scattered, and not so numerous on the left side; some of them, evidently formed by the aggregation of smaller lesions, present the appearance of large, flattened nodules, one or two of the largest being covered with adherent scabs. The sternal portion of the cicatrix is in a condition resembling "false keloid," and many of the larger lesions present the same appearance. The patient states that the affected surface often becomes covered with "pimples," which fill up with "blood and water." The disease is slowly growing worse, and itches greatly.

DR. ROBINSON thought the case a very remarkable one and very difficult of diagnosis. In examining it he had thought it was one of four diseases—eczema, lichen planus, keloid, or sarcoma. He had decided that it was not an eczema on account of the absence of exudation, transudation, vesiculation and scabbing, and also on account of the comparatively healthy condition of the skin between the spots. The situation of the eruption and the shape of the lesions excluded lichen planus. The course of the disease and its history, and the great number of the spots exclude a diagnosis of sarcoma. He was inclined, on the whole, to pronounce it keloid, although the patches do not very closely resemble ordinary keloid, except in density and elevation of surface. The bright-red color here present is found in young keloid before the contraction of tissue has progressed very far. The absence of the radiating processes around the spots could also be explained in this manner.

DR. FOX said that the case was unlike any that he had ever seen, and he found it impossible to make a diagnosis from one hasty examination by gaslight. He had been much surprised in hearing Dr. Robinson pronounce in favor of keloid, as only one of the lesions presented an appearance resembling that disease. Many of the spots are covered with scales and show a tendency to break down. He was inclined to regard the disease as a neoplastic growth of a "lupoid" nature, using the latter term in a very general way.

DR. BRONSON said the disease decidedly impressed him as not being of an inflammatory, but rather of a neoplastic nature. He could not agree with Dr. Robinson in calling it keloid, which disease always extends into the depth of the skin, being more extensive below than above, while in this case the surface is principally affected. He thought it unwise to ignore the original neoplasm which led to the removal of the breast, as he thought that the same structure might now be present, disseminated through the skin.

DR. MORROW said that he could not agree with Dr. Robinson's diagnosis, as he thought that true and false keloid rarely ever co-existed, and the latter affection is here present in the cicatrix. The extreme vascularity of the growths also argues against keloid. These masses can also be lifted up and completely grasped in the fingers without causing pain.

DR. DENSLOW exhibited a

CASE FOR DIAGNOSIS

and suggestions as to treatment. The patient, a man aged fifty years, had had the present lesion of the right side of the nose for fifteen years. He said that the disease began as a small black point in the skin which he tried in vain to squeeze out. It has continued to increase, and has been subjected to various treatments, including excision and cauterization. At the point mentioned is a pear-shaped loss of substance, extending very deeply, in its lower part going entirely through the free border of the right ala nasi, so that the adjacent edges of the lesion can be raised and a view obtained of the anterior portion of the septum nasi. The

ulcer is divided into an upper and a lower portion by a transverse bridge of relatively normal mucous membrane: the upper portion being of a circular crateriform shape, with shelving edges, the loss of tissue extending down to the mucous membrane. The raw edges of this part of the ulcer are clean and pale, secreting but little and presenting few, if any, granulations. The surrounding skin is but little indurated and seems comparatively healthy. The lower portion of the lesion is a vertical cleft through the whole side of the nose, the adjacent sides of it being covered with red granulations. The skin just behind it is the seat of a row of elevated semi-transparent, hard, whitish nodules, of a distinctly epitheliomatous aspect.

DR. MORROW would pronounce the disease rodent ulcer. As to treatment, he thought its total destruction indicated, the choice of the means used lying between cutting, scraping, and caustics, and of the latter he thought chloride of zinc the best.

DR. ROBINSON agreed with Dr. Morrow that the lesion was rodent ulcer or epithelioma. He would advise the use of Marsden's paste of arsenic, or any agent which would destroy the tissues and excite an active inflammation around the disease, so as to prevent absorption of the chemical employed.

DR. FOX would call it epithelioma, even if he recognized a distinction between that disease and rodent ulcer. As to treatment, he would prefer the use of the curette or the knife, preferring the former, following it with chloride of zinc or Marsden's paste, or the oleate of arsenic. The latter preparation he had recently used in lupus and scrofuloderma with very beneficial results and but little pain to the patients.

DR. BRONSON would make a very grave prognosis in the case. He thought the disease more extensive than it seemed to be: it had evidently extended up to the nasal bone, and that the greater portion of the nose would have to be removed in destroying it. For this purpose he would recommend Paquelin's cautery.

DR. FOX exhibited a case of

LESION OF THE CHEEK.

The patient, a healthy man, thirty years of age, had had the spot six years. It began as a small red point covered by a crust. This he would remove, and continue to remove as it reformed. The lesion is now an insignificant-looking pea-sized, dull-red, slightly moist excavation of a conical shape, with no change in the margin of the skin around it. A watery discharge small in quantity issues from it after he picks off the crust over it. The spot has lately increased but little in size.

DR. MORROW thought that the frequent removal of the scale covering the lesion well calculated to cause it to develop into a malignant growth. He thought there could be no possibility of the lesion being in any way connected, through the underlying tissues, with Steno's duct as had been suggested. He regarded the case as one of incipient rodent ulcer.

DR. DENSLOW thought the lesion connected with a follicle.

DR. FOSTER agreed with this opinion, and believed that it was kept from healing by the discharge from the follicle.

DR. BRONSON thought it either a lupus or an epithelioma. A simple inflammation, connected with a follicle, would not have lasted so long.

DR. FOX pronounced it an incipient epithelioma, though it was strange that this disease should occur in one so young.

DR. SHERWELL suggested that it might perhaps be a small fistula of Steno's duct, over the course of which it was situated.

DR. BRONSON exhibited a

CASE FOR DIAGNOSIS.

The patient, a girl, six years and a half old, had at birth, as the mother states, a red scratch-like mark at the point now diseased, she has never been free from

it. During summer the diseased patches are moist and oozing, during winter dry and scaly. She now presents on, but principally to the right of, the linea alba, midway between pubis and umbilicus, two irregularly-shaped patches, about the size of a fifty cent-piece, elevated, scabbed over, the upper one moist at a point where the scab has been removed. The scabs are of a grayish color, and the bases of the lesions are red, this color extending in the form of a narrow halo around them. At the upper part of the right labium majus is a smooth red glazed dense mass in the skin. Inguinal glands on left side are enlarged. There is no history of hereditary taint in the case.

DR. ROBINSON, at first sight of the case, had thought it one of chronic eczema, but would not now venture a positive diagnosis, in view of its congenital nature.

DR. BRONSON said the case presented certain features which the diagnosis of eczema would not account for. The growth in the labium is certainly not of an eczematous nature, yet it evidently has some connection with the disease above. To his mind the most probable theory was that the disease had some connection with a nerve. This origin would explain the intense pruritus present, which had caused the patient to scratch, and thus excite the element of eczema which is evidently present in the case.

DR. BRONSON exhibited a case of

FIGURED LICHENOID ECZEMA.

The patient was a young woman, seventeen years of age, of fair general health, but with phthisical antecedents. About one month ago, following "a cold with sore throat," an eruption appeared on the body, attended with itching. When examined one week later, the eruption occupied about the same locations as at present, but the lesions were more pronounced than they now are. The rash was most abundant over the thorax, especially upon the sides of the chest, where the spots were confluent. Upon the anterior surface of the chest, over the breasts, abdomen and back, the spots were either irregularly disseminated or arranged in figures. Linear, crescentic, and gyrate forms were abundant, the arrangement simulating that of a syphilitic or measly exanthem. The eruption extended also to the arms and legs, appearing upon all their aspects, but was somewhat less abundant in these situations than upon the trunk. The lesion apparently began as a minute papule of a light red or rose color, and seemed to gradually increase at the periphery till lenticular or larger spots were formed, or till they coalesced in confluent patches. Most of the spots were covered with light scales which in some of the very smallest were white silvery, rather adherent, and suggestive of psoriasis. There were no spots on the knees or elbows, and the lenticular spots showed only light scales or a furfuraceous desquamation. The confluent patches showed only this form of desquamation and moreover gave evidence of exudation with more or less erosion. When first seen, the eruption on the back presented the features of an eczema seborrhoecum (Kaposi), the scales being of a greasy character. The patient had considerable seborrhoea capillitii. The papules of the eruption, although presenting a sense of elevation to the touch on account of the scales, showed no distinct infiltration, and their color disappeared entirely under pressure. The itching, well-marked at first, had gradually diminished, till it was then insignificant. There had been no affection of the mucous orifices of the body, and no glandular enlargements. The treatment had been, locally, gentle soap frictions, followed by zinc ointment smeared lightly over the surface, with powdering, and internally, cod-liver oil and syrup. ferri iodidi.

DR. MORROW thought that the circinate character of the eruption suggested

syphilis or psoriasis. He was inclined to believe the case one of syphilis, notwithstanding the absence of a history of that disease.

DR. ROBINSON had seen one or two similar cases, and had one now under observation, in which the eruption comes and goes. In the present case he had detected by the aid of a lens a number of hidden vesicles. He would call it a case of eczema, the fact that the older the patches the less the scaling also inclining him to that view.

DR. SHERWELL said that at first sight it looked like syphilis. He thought it resembled the pityriasis circinata described by Unna, and if it were not a case of that disease, he would call it an unusual form of psoriasis.

DR. DENSLOW said that, judging from the history (of sore throat with fever), the tenderness over the sternum and the traces of a previous ulcerative process which he had found in the throat, and the rapid spread of the eruption, he would pronounce it a syphilide.

DR. FOX was convinced that the eruption was neither a psoriasis nor a syphilide. He also could recall two or three cases of disseminate guttate eczemas, in which the diagnosis was rendered positive by the existence of a number of moist patches. He thought this a case of eczema.

DR. FOSTER would say that the eruption was principally of an eczematous nature, but would like to satisfy himself that there was not an element of chromophytosis in the case.

DR. BRONSON said that there had been no dusky discoloration in the disease. Under the arm the eczematous appearance had been unmistakable. There never at any time have been any distinct evidences of syphilis, as he had satisfied himself by examination of the mucous orifices. The only point in which the disease resembled syphilis was the arrangement of some of the spots. The resemblance of the disease to a lichen scrofulosorum was well-marked. The papules are here too large in area, however, and they occur on the extremities as well as on the trunk.

DR. FOX exhibited photographs of the "Alligator-Boy."

The Society then went into executive session.

Correspondence.

DERMATOLOGY AND SYPHILOGRAPHY IN FRANCE.

(Special correspondence.)

THE TREATMENT OF VARIOLA BY OPIATE-ETHER MEDICATION, by Dr. M. Bucquet, Paris, 1882.

This method is not absolutely new, the first memoir upon the subject having been presented to the Academy of Medicine of Paris by Dr. DuCastel, August 30, 1881. But Dr. Bucquet has the merit of having collected in his work all the experiments which have been made in this direction by Messrs. Gombault and Dreyfus-Brisac, of Paris, by the physicians of the Hospital St. Eugene de Gille, and by M. Moyau, of Bordeaux.

This mode of treatment consists in administering by the stomach twenty or thirty centigrams of extract of opium and to make two deep injections of ether, each of one cubic centimetre, in the subcutaneous tissue or in the muscles; in grave cases one may make three or four injections. Ether, when taken by the stomach, exerts by no means the same action. In hemorrhagic forms the internal use of the perchloride of iron may be associated, but the author strongly doubts the efficacy of this last medicament.

This treatment modifies the progress of the eruption, transforms variola into varioloid, and in vaccinated subjects there is an abortion of discrete or confluent variolas without suppuration. In coherent variola, and even in the gravest confluent form occurring in persons already vaccinated, a cure without suppuration is very frequent under the influence of this treatment, and when suppuration does occur the accidents are extremely mild. In certain cases of pronounced confluent variola *in vaccinated persons*, a cure may result with or without suppuration of a trifling character. In *persons not vaccinated*, a cure under the influence of this treatment is exceptional; the rule is that the suppurative process is only attenuated. Finally, in variolas, hemorrhagic from the first, the treatment has absolutely no appreciable effect. In secondary hemorrhagic variola its influence is almost null. In view of these results, one may demand whether the abortion of the period of suppuration be due to the anterior vaccination. From a comparison of different cases, it follows that this opinion cannot be sustained. The variolous patients who, thanks to this treatment, avoid the period of suppuration, escape also the accidents which it engenders. The medication seems to act only during this period and upon the ulterior phases of the disease, but not upon the periods of invasion and of eruption. The author examines the inconveniences of the treatment, and in particular the accidents caused by the injections of ether; upon this point he reports quite interesting experiments, and affirms that these complications may be avoided by making the injections slowly, deeply, and in regions devoid of danger.

EXUDATIVE POLYMORPHOUS ERYTHEMA.

Fabre proposes in a voluminous article (*Gazette Méd. de Paris*, 1882), which includes numerous original observations, to designate exudative polymorphous erythema under the name of *the Malady of Hebra*. The papular, vesicular, bul-
lous, annular or circinate, marginate, gyrate, or figured erythemas, herpes iris, certain forms of hydroa and of pemphigus, ought to be grouped under this new morbid entity: for these different lesions are only modalities or different stages of the same elementary lesion—papular erythema. The malady of Hebra generally occurs in persons enfeebled either by former disease, by a condition of prolonged asthenia, or by various troubles connected with menstruation. There are individual predispositions; it may develop in the same persons several years in succession (annual type). It occurs more frequently in women, children, and adolescents, at the close of winter and during the spring. Urticaria, erythema nodosum, herpes iris, and chronic pemphigus are the diseases which more closely approach the malady of Hebra, and from which it is easy to make a differential diagnosis. *Per contra*, chilblains, certain forms of acrodynia, certain phlyctenoid onychias, and even symmetrical gangrene of the extremities, seem to the author to be allied in very close relationship to the malady of Hebra.

The general treatment is based especially upon the use of reconstituents and tonics, local medication in protecting the patches of exudation against irritations and frictions by the application of emollients and inert powders.

The subject of the PURPURA is the order of the day in France. All authorities admit that the lesions are badly defined, and they endeavor to classify them in distinct groups, more conformable to clinical truth than the ancient groupings. But they are far from agreeing upon this point.

1st. From numerous observations made in Algeria, in Senegal, and elsewhere, Dr. Didet (*Thèse de Paris*, 1882) concludes that hemorrhagic purpura shows itself in the course or at the termination of the malarial fever of hot countries; that it may perhaps be considered as a pernicious form of malarial infec-

tion: that the prognosis is graver in proportion to the chronicity of the malarial intoxication.

2d. Dr. Faisans (*Thèse de Paris*, 1882) believes that there exists a form of myelopathic purpura, characterized by a generalized eruption, quite symmetrical, and sometimes distributed along the course of the nerves. The eruption is accompanied in typical cases with disorders of sensibility, subcutaneous œlemas, arthralgias, and gastro-intestinal accidents. This form of purpura includes the greater portion, if not the totality of cases of rheumatic purpura, and it should probably have as an anatomical substratum an alteration diffuse and of a congestive nature, of the posterior portion of the spinal cord. The author does not fail to recognize that it is quite difficult to distinguish it, on the one hand, from the exanthematic form of simple purpura, and, on the other, from the malady of Werlhof; many French dermatologists regard them as purely arthritic manifestations.

3d. Dr. Mathieu, in an essay on the subject (Paris, 1883), attacks that which has heretofore been designated under the name, *Purpura Hemorrhagica*. He believes that it is not a distinct affection, but simply a symptomatic manifestation, the nature and cause of which may be different, according to circumstances. He endeavors to describe several clinical forms which should be thus classed. He commences with the *malady of Werlhof*, which is characterized by the rapidity of its *début*, the insufficiency of its causes, the absence of fever, primarily at least. He arranges in the same category *purpura hemorrhagica of slow evolution*, which he considers as a special chronic form of the malady of Werlhof—a form impossible to distinguish from *sporadic scorbutus*. He sustains this latter view, which is that of Prof. Lasègue, in basing it especially upon the cases of benign scurvy observed in the prisons of the Seine, cases absolutely analogous in symptomatology with cases known as purpura hemorrhagica of slow evolution, non-epidemic, and not referable to any etiological cause. He readily connects the *purpura myelopathique* of Dr. Faisans with arthritism. Finally, after having described the infectious hemorrhagic purpuras which are seen in general diseases, he admits the existence of an *essential infectious hemorrhagic purpura*. This is the febrile purpura of Rayer; he mentions a *rapid form* in which death may occur in from twenty-four to forty-eight hours; a *form more slow* and insidious, although grave: a *gastric form*; finally, a *pseudo-rheumatismal form*. In the author's opinion, the characteristics of the infectious forms are the general condition of the patient, the typhoid aspect, elevated temperature, the tendency in certain cases to pseudo-rheumatismal arthritis, to abundant multiple hemorrhages, to ecchymoses rather than petechiæ. The author terminates his work by inquiring if, on the other hand, purpura occurring in certain diseases may not be invoked as a proof of their infectious nature.

4th. The thesis of Dr. Ducastel is one of the best critical reviews which we have upon the subject. It contains all the ideas of preceding authors. It is original only from one point of view, but extremely important. With the majority of the physicians of the Hospital St. Louis, Dr. Ducastel declares that *purpura is not a morbid entity*, it is *only a symptom*, only a symptomatological expression common to a number of pathological states which he endeavors to classify. It is impossible for him to recognize pathological unity in purpura hemorrhagica and in the malady of Werlhof.

5th and 6th. Drs. Rougon (*Union Méd.*, Feb. 4, '83) and Barthélemy (*Arch. Gén. de Méd.*, Dec., '82) publish cases of hemorrhagic purpuras terminating in death. That of Dr. Barthélemy is quite important, for it was followed by a carefully con-

ducted autopsy and a very complete histological examination. Unfortunately, it did not clear up the question, and the author proposes in his work to resume the old classification of Rayer—*purpuræ febrile* and *purpuræ non-febrile*.

V. PATHOLOGICAL ANATOMY OF LUPUS, by Drs. Vidal and Leloir (*Société de Biologie*, Nov. 18, 1882). This work constitutes a very interesting and very complete chapter of pathological anatomy. It is a succinct resumé of the researches of authorities upon the histology of lupus; and is extracted from their great work on the pathological anatomy of cutaneous diseases, which will appear with an atlas in a short time. They conclude as to the morphological similitude of tubercular lupus with tubercle, while adding that clinical considerations (evolution and symptomatology), as well as experimental (negative inoculation) prevent them from regarding lupus as a local tuberculosis.

They describe a new form of lupus—*sclerous lupus*, which manifests itself in the form of spots, or small circumscribed tubercles, of a deep-red or violaceous hue, showing themselves later as unequal, rugous, mamillated projections, covered in certain points with verrucose, sometimes corneous excrescences, separated by furrows and fissures. Superficial sections of these lesions resemble epithelioma, but in deep sections are found islets with infiltration of embryonic cells, and the vascular lesions characteristic of lupus. Sclerous lupus is a tubercular lupus which has become fibrous; it bears the same relation to tubercular lupus as the fibrous tubercle to tuberculosis.

Histologically, the different varieties of erythematous lupus are characterized by a diffuse infiltration of the derma, the return of the walls of the vessels to an embryonic state, the tendency to hemorrhage, vascular dilatation, etc. They insist upon the point that in *lupus erythematæ-acneique* the embryonic infiltration, while diffuse, is excessively profound, and invades sometimes the subcutaneous cellular tissue, in being predominant around the sebaceous glands, which are hypertrophied and infiltrated with embryonic cells, and later they become filled with dry and horny epidermic cells.

PARIS.

BROCQ.

Reviews.

A PRACTICAL TREATISE ON DISEASES OF THE SKIN. FOR THE USE OF STUDENTS AND PRACTITIONERS. By JAMES NEVINS HYDE, A.M., M.D., Professor of Skin and Venereal Diseases, Rush Medical College, Chicago, etc. etc., pp. 572. Philadelphia: Henry C. Lea's Son & Co., 1883.

No better evidence could be furnished of the growing interest in dermatology in this country and the zeal and industry with which this branch of general medicine has been cultivated, than the number of distinctively American text-books which have appeared within the last decade. The standard works of Duhring and Piffard, the admirable atlas of Fox, the numerous monographs of other writers, to say nothing of even more important forthcoming works, of which it would be premature as yet to speak, all attest a remarkable productive activity in this special field. In no other department of medical science has there been such an array of earnest and enthusiastic workers. The results challenge comparison in solid worth and scientific value with the contributions coming from

the older and long established schools of Europe, and have been accepted as permanent acquisitions to the literature of the subject. The impetus given to the study of dermatology in this country has resulted not only in the training up of a class of skilled specialists, but in the diffusion of more accurate and thorough knowledge of diseases of the skin among the masses of the profession at large. The importance of this study has come to be recognized by our representative institutions of learning, so that to-day the curriculum of no medical college is considered complete in which dermatology is not taught.

Prof. Hyde has long been known as one of the most intelligent and enthusiastic representatives of this specialty in the West. His numerous contributions to the literature of dermatology have gained for him a favorable recognition as a careful, conscientious, and original observer.

The remarkable advances made in our knowledge of diseases of the skin, especially from the stand-point of pathological histology and improved methods of treatment, necessitate a revision, at short intervals, of the older text-books in order to bring them up to the standard demanded by the march of science. This last contribution of Dr. Hyde is an effort in this direction. He has attempted, as he informs us, "the task of presenting in a comprehensive form the results of the latest observation and experience." A careful examination of the work convinces us that he has accomplished his task with painstaking fidelity and, in the main, with a creditable result.

The section on the anatomy and physiology of the skin is illustrated by admirably executed drawings and embodies the latest researches made in the morphological histology of the cutaneous tissues.

In his general symptomatology, Dr. Hyde has discarded the old division so long followed of classifying the elementary lesions as primary and secondary, and has adopted the terms, lesions and lesion relics, to express the objective characters attending the development and decline of the inflammatory process. In the section devoted to the general etiology of diseases of the skin, the author has little sympathy with what he terms the "prevalent doctrines respecting blood poisons of internal origin." The influence of such conditions in the causation of skin disorders he regards as exceedingly restricted. The nervous origin of many cutaneous affections is not alluded to in this chapter. The intimate relations existing between the nerves and the nutrition of the skin, the influence of mental emotions, of lesions of the central and peripheric nerves in the production of eruptive phenomena, which have been demonstrated by the recent researches of Leloir, Lewin, Schwimmer, and others, should, it seems to us, have received recognition. Heredity as an etiological factor is regarded as of little importance. The diathetic tendencies expressed by the terms rheumatic, herpetic, scrofulous, etc., are practically ignored, while the influence of internal causes, such as constitution, habit, temperament, age, sex, etc., receives but scant recognition.

The author declares that "the large proportion of all diseases of the integument originate either from the action of solar heat and light; temperature changes at the surface of the body; contact with various fluid and solid substances with the production of either frictional, traumatic, or toxic effects, or the development upon and within the skin of vegetable parasites." The list of toxicants includes the poisons of animal origin which give rise to the exanthematous fevers, glanders, farcy, malignant pustule, and syphilis.

In the chapter on diagnosis, the rules for the examination of the objective symptoms, or the lesions present on the surface of the body, are complete, exhaustive, and elaborated with much detail. From the little importance which the

author has assigned to the constitutional origin and relations of skin diseases in general, more significance is attached to the history of the patient, the condition of the digestive, respiratory, circulatory, genito-urinary, and nervous system than we would have expected.

The conception of the etiology of a disease has a very important bearing upon its treatment, and recognizing, as the author does, the purely local origin and nature of most skin diseases, we are not surprised to find that he is rather inclined to depreciate the value of constitutional means, although he by no means advocates an exclusively local treatment.

Speaking of the large number of medicinal agents used internally, he says, "with few exceptions given below, not one of them is known to exercise the slightest remedial action upon the surface of the body." These exceptions are "arsenic, mercury, iodide of potassium, cod-liver oil, quinine, ergot, and carbolic acid: of them all it may be said, that while each possesses a wide range of usefulness, no one of them can be certainly trusted to produce a given effect; and each in many cases is either positively prejudicial or without efficacy of any kind." Eliminating from this list mercury and iodide of potassium, which are almost exclusively recommended for the syphilodermata, we perceive that the author's armamentarium is exceedingly limited.

The classification followed by Dr. Hyde is a modification of Hebra's and based upon anatomico-pathological peculiarities, possessing, however, certain advantages upon the latter which he points out. He also gives the classification adopted by the American Dermatological Association, the merits of which he concedes, so that the judicious reader may compare and take his choice.

We have not space to enter into an examination of the manner in which the different groups of diseases embraced in this classification are taken up and treated. To refer to only one class, which may be regarded as the type of skin diseases in general and which is by far the most important—the author asserting that eczema alone, in its manifold forms, furnishes more than one-half of all diseases of the skin—Dr. Hyde commits himself clearly to the theory of the local nature of eczema, and ridicules the adherents of the French school who believe that for the production of a true eczema a constitutional predisposition is an essential requisite. He makes no distinction between eczema and artificial dermatitis, but asserts that "every phase of eczema can be artificially produced upon the surface of the skin by the action of external irritants."

The "autonomy of the integument" is insisted upon, and the fact that "eczematous affections occur in the persons of individuals who are in every respect superb examples of good health" is brought forward as proof that the skin eruption is not symptomatic of a disorder of the general system. The "so-called internal causes of eczema" he regards "as conditions or coincidences which favor the development of diseases in general." In the therapeutics of acute eczema, as well as in many of the chronic forms, the principles of treatment are formulated in the one indication: "The exclusion of all sources of irritation," which is capitalized in order to render it most emphatic. If this "could be perfectly secured in any case, no other treatment would be required." While conceding the correctness of this principle of treatment, most authorities give it a much more restricted application. Fourteen and a half pages are devoted to the consideration of the local management of eczema, while the constitutional treatment is limited to one and a half pages, the greater portion of which is occupied in the condemnation of constitutional means on general principles. He declares that "there is no constitutional treatment of the disease, save that which excludes all sources of irritation." Arsenic he re-

guards as "an uncertain remedy in all cutaneous diseases; it is, if possible, more uncertain in eczema; and has unquestionably aggravated more cases than it has relieved."

However disappointing the internal treatment of eczema given by Dr. Hyde may appear from the stand-point of those who believe in the constitutional relations of the disease, it must be conceded that he atones in a measure for the deficiency, by the variety and completeness of the list of remedial agents which he recommends in its local therapy.

The criticism which we would pass upon the work before us is that it is too strongly tinctured with the doctrines and teachings of the Vienna school. While we admire the genius of its illustrious founder and do full justice to the immense value of his services to dermatology, in bringing order out of confusion and reconstructing the classification of skin diseases on a sounder and more scientific basis, yet it cannot be disputed that Hebra was an extremist in his peculiar etiological views. Although a majority of American dermatologists, attracted by the renown of Hebra, were educated in this school and caught their first inspiration from this great teacher, yet his theory of the purely local pathology of skin diseases has never distinctly dominated dermatological thought and practice in this country. Many of his most enthusiastic pupils have abandoned the dogmatism and exclusiveness of their master and no longer ignore the line which connects diseases of the skin with disorders of the general system.

It would seem that Dr. Hyde has not recovered from the bias of Hebra's teachings. His book, in which the broad and fundamental doctrines of the constitutional origin and relations of diseases of the skin find no recognition cannot be considered, to this degree at least, as a fair exposition of American dermatological ideas and practice.

CHRONIC MILIARY SUDAMINA.

1. THERE exists as a sequel of acute sudamina (whether sporadic or epidemic) a hitherto undescribed form of the disease, for which I suggest the name *chronic miliary sudamina*.

2. In the majority of cases it follows in the course of a protracted convalescence from the acute form of the malady. Sometimes, however, in a district infected by acute sudamina, it occurs spontaneously and primarily, or after a short subacute stage.

3. According to my observations, it affects grown-up persons exclusively, and females are rather more liable to its attack than males.

4. Its leading symptoms resemble those of cerebro-spinal irritation, as described by Jaccoud. They are habitual and profuse sweats; a discrete and scanty miliary eruption; marked muscular paresis; persistent weakness of the stomach, followed by subjective sensations of heat and cold; neuralgic or rheumatic seizures; severe epigastric pains, and palpitation of the heart.

5. The complaint seldom varies in its manifestations, and lasts from a few months to three or four years, with a tendency to spontaneous cure.

6. Sulphate of quinine will be required in a few cases of chronic miliary sudamina, but, as a general rule, cold water and the continuous galvanic current are the only reliable remedies.—PINARD, *Le Courrier Médical*, September 23, 1882.



Schroder. Fig. 1.



Schroder. Fig. 2.

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Original Communications.

LEPROSY IN THE UNITED STATES.

BY

HENRY G. PIFFARD, M.D.

THE increasing prevalence of Leprosy in this country, and the admitted fact that it is capable of being transferred to previously healthy persons, renders it expedient that special attention should be called to it at this time. The writer's first experience with the affection dates back to the year 1864, at which time he served as interne at Bellevue Hospital, in one of the wards of which there was a leper. Since then there have come under his observation upwards of thirty cases. Some of these were under his immediate care, while others were either private or hospital patients of his professional friends. This experience has enabled him to observe the disease in all of its principal forms, both pure and complicated with other affections. It, however, is dwarfed into insignificance in comparison with that obtained by many observers in parts of the world where the disease is endemic, or has acquired a decided foot-hold. At the present time the writer has under his care four cases in the dermatological wards of the Charity Hospital, on Blackwell's Island, New York. The history of these cases will be briefly given, after which there will be a few remarks concerning the disease in general, especially from the stand-points of diagnosis, prophylaxis, and treatment.

CASE I.—James E., now twenty-two years of age, consulted me concerning an eruption on the skin about two and a half years ago. On inquiry I obtained the following history. He was born on the Island of

Bermuda of English parentage, suffered from typhoid and yellow fevers, and the usual diseases of childhood, and was brought to this country by his parents when about twelve years of age. After residing here two years he noticed brownish discolorations about the hips, followed by similar lesions on the thighs, legs and arms. A year later he returned to Bermuda where the affection gradually became worse, and tubercular bosses appeared on the forehead. These later appeared on the legs and arms. He returned to the United States about three years ago, and shortly after came under the writer's observation. At that time he exhibited the tubercular form of the disease in its most characteristic phase. In addition there were evidences of the previous macular condition, as well as impairment of sensation in the extremities. I advised him to enter the Charity Hospital, which advice he followed, and he has been there ever since. See Plate, Fig. 1.



FIG. 3.

CASE II.—Peter A. first came under notice in January last, bearing a letter from Dr. M. Magelssen of Albert Lea, Minnesota, who had referred him to me. From Peter, I obtained the following history: He was twenty-six years of age and was born in Norway. He came to the United States when a child, and has resided here ever since. Beside the other members of his family who immigrated at the same time, there was an aunt who was a sufferer from leprosy. Six years ago the first symptoms of his present disease appeared. When he came under notice, his face and body were covered with tubercular and ulcerative lesions, and there was impairment of sensation at different parts of the cutaneous surface. He was admitted into Charity Hospital January 23, 1883. The appearances presented are shown in the Plate, Fig. 2.

CASE III.—Adolph M., a native of the West Indies, was admitted into Charity Hospital March 14, 1883. He states that his father was a Dane, and his mother a native of the West Indies. About eleven months ago, sores appeared on various parts of his body, together with small lumps on his face. He came under personal observation April 1, at which time the following lesions were present. First, pustulo-crustaceous lesions having the aspect of syphilitic rupia; second, a profuse tubercular eruption involving the face and ears; third, macular lesions on various parts; fourth, enlargement of the ulnar nerves; fifth, impairment of sensation. The diagnosis was leprosy and syphilis. He was placed on anti-syphilitic treatment, and in a few weeks the pustulo-crustaceous lesions disappeared, while the other lesions mentioned were unaffected by the treatment. During the month of May he had an attack of leprous fever, followed by an eruption of characteristic leprous tubercles on the leg. (Fig. 3.)



FIG. 4.

CASE IV.—Oney J., born in China, twenty-four years of age, was admitted into Charity Hospital April 2, 1883. This patient came to the United States when quite young, residing the greater part of the time in California. His present trouble first made its appearance three and a half years ago, as a tubercular eruption on both cheeks, which gradually extended over the face. On admission his face was found to be covered with tubercular masses, varying from the size of a pea to that of an almond. On the back and elsewhere there were leprous discolorations, the ulnar nerves were enlarged, and there was hyperæsthesia of the skin of the extremities. (Fig. 4.)

HISTORY.—From the earliest times of which history gives account, we find mention of the disease now commonly known by the name of leprosy.

The word occurs in the English versions of both the Old and New Testaments, and in the former undoubtedly has reference to the disease under present consideration. In the New Testament the word appears as a translation of the Greek word *λεπρα*, a term applied by the older Greek medical writers to the disease now called Psoriasis. Leprosy proper was called Elephantiasis, to which name modern writers usually add the term *Græcorum*, to distinguish the affection from a totally different disease called elephantiasis by the Arabians.

Leprosy has prevailed to a greater or less degree in almost every portion of the known world, from the frigid zone to the tropics; but at the present time is chiefly found under the extremes of temperature, being much less prevalent in the temperate zones. In North America it prevails in Mexico, Louisiana, California (among the Chinese), Wisconsin, and Minnesota (among Norwegian settlers), in New Brunswick, B. A., and among the Indians of the Northwest. Beside this, cases are encountered among immigrants from countries where the disease is specially prevalent, particularly the West Indies, South America, and the Sandwich Islands. It is from the three latter countries that most of the cases have come that have fallen under my observation.

LESIONS, VARIETIES, and SYMPTOMATOLOGY.—The lesions of leprosy occur in the nervous system, in the mucous membranes, in the skin, and elsewhere. In the nervous system we find changes in the spinal cord and nerves, the ulnar nerve being the one most conspicuously affected. Among the earlier changes is swelling of the nerve, followed by atrophy. The mucous membranes, particularly of the mouth and throat, become the seat of tubercular formations, which, later, may undergo ulceration. On the skin we find macules, bullæ, tubercles, and ulcerations. The three principal varieties or types of the disease are the macular, the anæsthetic, and the tubercular. It is exceedingly rare to find an individual case, however, that exhibits either type in its purity. As a rule, all cases exhibit a mixture of types, with one or the other prevailing. Before the symptoms of the disease become clear and unmistakable, there is usually a prodromal stage of varying duration, characterized simply by a gradual impairment of the general powers, both physical and mental. Occasionally a brownish discoloration (*macule*), or an isolated bulla may appear from time to time, the first one usually healing before the second one makes its appearance. Later the macules become more abundant and larger, reaching the size of the palm of the hand, but are not accompanied with any appreciable degree of infiltration. At first they are of a reddish-brown, and as they increase peripherally, their advancing border retains this color, while the more central portions lose it, and fade away into a dirty gray, or even a dead white. The sites of these discolorations are at first slightly hyperæsthetic, but as the disease progresses, this condition gradu-

ally disappears and is succeeded by anæsthesia. In connection with the macules, or even without them, tubercles may arise. These are thickened elevations of the skin, sometimes quite circumscribed, at other times more diffuse. The tubercles may exhibit the normal coloration of the skin, or the color may be heightened. At first they may be hyperæsthetic, later becoming anæsthetic. They may appear upon any part of the body, but usually make the face their favorite seat, showing themselves on the forehead, about the lips, and on the ears. When they are developed to any great extent, they render the features repulsive and disgusting to the last degree, sometimes causing a leonine appearance. The tubercles frequently persist unchanged for a very long time, even perhaps throughout the whole continuance of the disease. Sometimes, however, they undergo ulceration, or disappear by interstitial absorption. Accompanying the tubercles there may be patches of skin which are anæsthetic, but which exhibit no other apparent change. This anæsthesia may be temporary or permanent. Coincidentally, or subsequently, the mucous membranes of the buccal cavity, nares, pharynx, etc., may exhibit tubercular lesions.

The *anæsthetic* form of leprosy may arise as a late stage in the course of a case which, at the beginning, had exhibited macular or tubercular features only, or it may arise without such previous tubercular development. The cutaneous lesions met with at the beginning of this form are usually *bullæ*, which vary in size and persist for a short time only. They usually rupture, dry up, and leave a stain, which, after a time becomes anæsthetic. Hyperæsthetic patches of varying extent may appear from time to time, and persist for months or longer, and be ultimately succeeded by anæsthesia. The finger ends often become enlarged and clubbed, and covered with glossy skin. The anæsthetic portions of skin may undergo a certain degree of atrophy, which processes may also involve the subcutaneous tissues, and result in ulceration, and if situated on the hands or feet, to caries of the bones of these parts. This may result in total loss of the fingers and toes, and even involvement of the metacarpal and metatarsal bones.

According to the researches of Danielsen and Boeck, in Norway, the average duration of the disease is about twelve to fifteen years.

DIAGNOSIS.—The diagnosis of leprosy in the very earliest stages is unquestionably difficult, and in many cases undoubtedly impossible; but when the disease has fairly opened, and exhibits any of the lesions mentioned, namely, brownish patches, bullæ, tubercles, sensory disturbances, enlargement of the ulnar nerves, etc., suspicion should be awakened, and if on inquiry it be ascertained that the patient has formerly lived in a country where the disease is endemic, or has been in familiar intercourse with a person suffering from leprosy, the suspicion will be greatly

strengthened. If two or more of the symptoms mentioned are found to be present, the diagnosis is almost certain. As regards differential diagnosis, the following points should be borne in mind: sensory disturbances should be differentiated from those that result from other essential affections of the spinal cord and nervous trunks; bullæ from those dependent on pemphigus; tubercles from the similar lesions of syphilis. While in the great majority of cases the diagnosis can be made with little difficulty when the lesions are well pronounced, still occasionally it is otherwise. The writer some time since was asked to see a case in which he was unable to decide whether the patient had leprosy or syphilis, or both, and there is in the city at present a case in which there is doubt as to whether it be a case of leprosy, or some essential disease of the spinal cord.

ETIOLOGY.—The etiology of leprosy is obscure. Diet, climatic influences, and bad hygiene, all have been brought forward to account for the prevalence of the disease, in certain countries. These, however, cannot be regarded as entitled to much weight, insomuch as we find the most opposite conditions prevailing in this respect in regions where the disease is of frequent occurrence. Hereditary influence is a much more probable factor. Direct contagion, however, is unquestionably the most frequent cause of the spread of the disease, though the exact manner in which it is effective has not yet been discovered. This question, however, has been so ably discussed by Dr. J. C. White in a paper read before the American Dermatological Association, that we will simply refer the reader to that paper, or to the abstract of it that appears among the selected articles in the present number of this JOURNAL.

HISTOLOGY.—During the past few years, the histology of leprosy has undergone a complete revision, but cannot as yet be considered as fully established. The changes in the nervous system have been carefully studied by Hoggan and others, while the discovery by Hansen and Neisser of bacilli in the tubercles throw new light on the subject, but the exact bearing of these researches cannot as yet be considered as definitely settled.

PROPHYLAXIS.—We presume that no one will dispute the proposition that it would be exceedingly unfortunate if leprosy should gain the foothold among us that it has acquired among certain other peoples, the Norwegians, for instance, and still more notably, among the inhabitants of the Sandwich Islands. It is hardly more than forty years since it was first introduced among the inhabitants of those islands: yet in that time it has already claimed nearly ten per cent among the natives of that region as victims. It is not at all probable that the disease would spread in America with anything like the rapidity that it has in some other countries, but the fact remains that several cases of leprosy are on

record in which the disease originated in this country under circumstances that lead directly to the conclusion that it is perfectly capable of increasing among us from direct contact with imported lepers, as in the case of Peter A. reported above. Under these circumstances, it would seem wise that measures should be taken early, while the evil is still in its infancy, to protect the people from further danger.

This can be accomplished only through national legislation; and to this end we would urge on Congress the necessity of providing, first, a central Lazaretto; second, immuring therein all lepers now in the country; and third, watching immigration, and giving each leprous immigrant the option of returning to the country whence he came, or of entering the Lazaretto. This will have to be done sooner or later, and the sooner it is done, the less difficult will be the undertaking.

TREATMENT.—As regards this branch of the subject, it may be briefly stated that, as yet, no specific for the disease has been discovered. It is also problematical whether the affection is susceptible of absolute cure. Per contra, we are fully justified in stating that rapid amelioration may often follow judicious treatment, even in the advanced stages of the disease, as we have more than once witnessed. We have recently (*Materia Medica and Therapeutics of the Skin*, pp. 200-208) considered this subject at length, and can at present state that the drugs that have appeared to exert the most decided influence on the affection are nuxvomica and its derivatives, and chaulmoogra oil. With these, the progress of the disease can be stayed, at least for a time, and the unhappy sufferers restored to a condition of comparative comfort. More than this we do not feel warranted in promising.

THE BACILLUS OF LEPROSY.

BY

WM. T. BELFIELD, M.D.,

Chicago.

FOURTEEN years ago, Hansen announced the discovery of bacteria in certain cutaneous nodules removed from patients afflicted with tubercular leprosy. His demonstrations were not, however, entirely satisfactory; for he offered no other proof of the bacterial nature of the bodies in question than their general appearance, size, and shape; and the methods which he employed, though the best then devised, failed to give a satisfactory picture. At this time, indeed (1869), but little attention had been bestowed by pathologists upon the possible patho-

genetic relations of bacteria, and had Hansen furnished even an unequivocal demonstration of his assertion, it is scarcely probable that the incident would have attracted much attention.

Within the next decade, however, the rôle of bacteria in disease became a question of absorbing interest, an object of most extensive and assiduous investigation. Among the fruits of this study were the introduction of accurate and trustworthy methods for the detection and recognition of bacteria—for distinguishing these minute organisms from cell-débris, crystals, organic granules, and other objects of similar appearance. These methods—due chiefly to the ingenuity and industry of Weigert and of Koch, consist, as is well-known, in the use of the aniline colors for staining, of the Abbé illuminator, and of special methods for the cultivation of bacteria. In 1878, Neisser, then a private docent in Leipzig, now professor of dermatology in Breslau, having thoroughly familiarized himself with these methods, spent some months in Spain for the express purpose of studying the pathology and histology of leprosy. He reported¹ as the result of these investigations the presence of a bacillus of specific size and shape in every leprous patient, yes in every leprous tissue examined; not only in the cutaneous nodules, but also in the neoplasms of the mucous membranes, mouth, pharynx, and larynx; in the liver, spleen, lymph-glands, nerves, cartilage, and testicle. He was unable to detect the organisms in the blood.

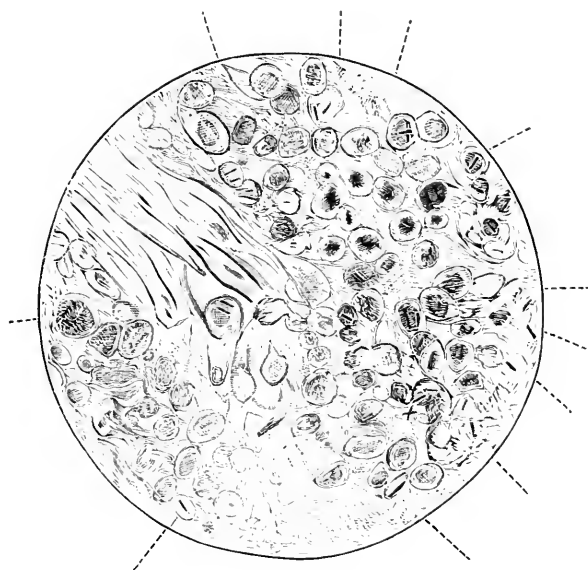
Examinations by other observers, prominent among whom may be mentioned Eklund and Köbner, have unanimously confirmed these assertions of Neisser, and have demonstrated the accuracy of the original observations of Hansen. Although leprous tissue is comparatively scarce material, and opportunities for observation therefore somewhat limited, yet there has been such perfect unanimity of results among all observers as to justify generalization. For no one who has sought *intelligently*—*i. e.*, has properly used the aniline colors, etc.—has failed to find the bacilli in tissues properly preserved and not too old.² So far as I am aware, Dr. H. G. Schmidt, of New Orleans, is the only observer who has recorded his failure to find the bacilli; he did not employ the aniline colors—in fact, did not stain his sections at all, if I may judge from one which I happen to possess. It is to be hoped that recent developments as to the necessity of certain manipulations in detecting the bacillus tuberculosis may induce Dr. Smith to employ these more accurate methods in seeking the bacillus lepræ.

The bacteria are found usually within the characteristic large cells which constitute the mass of the leprous neoplasm; sometimes two or

¹ Virch. Arch., Bd. 84.

² After soaking in alcohol for some years or even months, the bacteria often fail to respond to the staining agent, and may be therefore readily overlooked.

three bacilli may be seen in one of these cells. Occasionally a few stragglers are observed lying in the intercellular spaces also. The individual rods are $\frac{1}{5000}$ to $\frac{1}{6500}$ inch in length, often somewhat thicker in the middle than at the extremities, exhibiting therefore a spindle-shape. Like other bacteria, they are characterized by their affinity for certain (basic) aniline colors—blue, red, and violet especially. In sections of recent tissues the bacilli can be stained with the ordinary two-per-cent aqueous solution of the aniline colors; if the tissue has been long exposed to alcohol, the sections should be first treated with a five-per-cent watery solution of



acetic acid, and then transferred to a ten-per-cent solution of caustic potash, after which they may be stained.¹

The writer's personal knowledge of these bacilli is limited to two cases. A cutaneous nodule was removed *intra vitam* from a private patient by Prof. v. Frisch, of Vienna, and placed at once in absolute alcohol. Sections made a few days later and stained with aniline showed the bacilli in and among the large cells which constituted the mass of the nodule. During a recent visit the writer had the pleasure of exhibiting one of these sections to numerous gentlemen in New York and Phila-

¹ For details see Appendix B. to the author's "Cartwright Lectures," W. T. Keener, Chicago, 1883.

delphia, including several members of the New York Dermatological Society.

The second case was a patient in New York, from whom a piece of skin was excised and presented to me by Dr. H. G. Piffard; sections treated with aniline gave essentially the same appearance as in the first case, except that the bacilli were perhaps less numerous. The accompanying cut is copied from a photograph of one of these sections.

But little is known as to the natural history of this fungus. Neisser made cultures from lepra-nodules on blood-serum and beef-extract; he says that the rods grew into threads; that in these threads there subsequently appeared round glistening bodies which he regards as spores. Yet further observation on this point is needed.

It is then established that a bacterium—a bacillus—of specific size and shape is a constant element of the diseased tissues in tubercular leprosy; yet this fact of association does not of course prove that the bacillus *causes* the morbid process; since it is conceivable that it appears as a sequence rather than as a cause of the disease. This latter conception is certainly not entirely satisfactory; it does not plausibly explain why this bacterial variety, and this one only, is found and *always* found in the leprous nodules—but in no other diseased state. We attribute trichinosis to the trichina spiralis, though we have no other proof of a causal relation than the mere presence of the worm; we ascribe chyluria and lymph-scrotum to the filaria sanguinis hominis, although we know only that this worm is sometimes present in these morbid conditions. Yet the some men who accredit these two worms with morbid influence merely because of their association with diseased states, reject the idea that the bacillus of leprosy is anything more than the *result* of a previously established morbid process.

Yet we are justified in declining to admit the causal relation of the bacillus from mere analogy, if direct demonstration be possible; and in the case of at least one other bacterium such demonstration has been actually furnished. The bacillus anthracis, as is well known, has been cultivated outside of the body on prepared media; has been separated by successive cultures from all animal tissues; has been in short isolated. And it is an equally familiar fact that these bacilli thus isolated and then introduced into the tissues of a healthy animal, induce a classical anthrax. Until an equivalent demonstration shall be furnished for the bacillus leprae, the proof of its causal relation to leprosy may be regarded as incomplete. Yet it is evident that the matter cannot be so easily decided for leprosy as for anthrax, since the former disease is peculiar to the human subject—a subject not usually available for experimental purposes of this nature; it seems indeed impossible to furnish the final link in the chain of evidence in leprosy.

Neisser has, it is true, inoculated animals—dogs and rabbits—with the

isolated bacilli lepræ, and asserts that nodules similar to those of leprosy in the human subject were produced at the site of inoculation. Yet one nodule does not make a leprosy, nor is there in fact satisfactory evidence that Neisser's nodules were of other than simple inflammatory origin.

Such, then, is the status of the question to-day; the association of a specific bacillus with the morbid changes of tubercular leprosy is established and admitted; while the relation of the parasite to the morbid process is not as yet established by direct demonstration.

The bacillus has not as yet been detected in the so-called anæsthetic form of leprosy.

THE TREATMENT OF ECZEMA.

BY

DR. MCCALL ANDERSON.

(Continued from page 273.)

THE local application of TARRY PREPARATIONS is of the utmost value, and has long been in vogue in the treatment of eczema, but they have been far too frequently used in a routine way, and without discrimination. When any of those conditions are present to which I have already referred as indicating the necessity for using soothing applications, they are, as a rule, decidedly contraindicated; for it must ever be borne in mind that tarry preparations are chiefly of use when the eruption is chronic or declining. Even then it occasionally happens, owing apparently to the skin being unusually sensitive, that the disease is aggravated instead of ameliorated by them, or that a chronic is converted into an acute eruption. Hence they must be employed at first with due care, and sufficiently diluted.

Those most applicable for dispensary patients, owing to their cheapness, are wood tar (*pix liquida*), coal tar (which I prescribe under the name of *pix mineralis*), and Burgundy pitch (*pix burgundica*); but in private practice, when expense is no object, more elegant preparations, such as *oleum rusci* or *oleum cadini* (oil of cade) may be employed. The former of these is the product of the bark of the white birch, the latter of the dry distillation of the wood of the *Juniperus oxycedrus*,¹ and should be obtained from Aix-la-Chapelle, else a liquid prepared from common tar is apt to be supplied in its stead.

Whichever of these preparations is selected should be rubbed firmly

¹ "Medicines: Their Uses and Mode of Administration," by J. Moore Neligan, M.D. Fourth edition, p. 405. Dublin.

over the eruption by means of a piece of flannel, and allowed to dry upon it. It may be applied once or twice daily, or oftener, if the irritation of skin, which is moderated or allayed by its use, returns before the stated time for its reapplication. It should be washed off as well as possible with soft soap, or, amongst the higher classes, with one of the toilet soaps, to which I shall shortly refer, before it is renewed.

In many cases it is more appropriate to prescribe tarry preparations in the form of ointments, particularly when the parts feel stiff and rigid, and when there is a tendency to the formation of fissures. They may be applied in the form of the *unguentum picis liquidæ* in a diluted form, or variously combined, as in the appended formulæ.¹

Various kinds of soaps, containing tar and oil of cade, may be used, and often with some benefit. Of these the cade soap, manufactured at Aix-la-Chapelle, is one of the best; but it is too expensive for many patients (each ball costs 3s. 6d.). A cheaper soap, called the "juniper tar-oil soap," is manufactured by Sellers;² and soaps made from mineral tar, and which are equally cheap, are manufactured by Rieger (under the name of "medicinal tar soap"), and by Wright & Co.³ (under the name of "*sapo carbonis detergens*"). The last is a pleasant soap to use, although it contains so small a quantity of tar as to be comparatively valueless by itself in well-marked cases of eczema. These soaps should be employed like common soap, but rubbed more firmly over the parts; and in many cases it will be found of advantage to allow them to dry upon the eruption.

A most valuable way of using tar is in the form of lotions, and it may be combined in various ways, as, for example, with one of the potash solutions. A most admirable preparation, one of Hebra's, and which is used to a great extent at the Dispensary for Skin Diseases, Glasgow, under the name of "*tinctura saponis viridis cum picæ*," and often with the most charming effect, is a mixture of equal parts of common tar, methylated spirit, and soft soap, which should be applied exactly in the same way, and as frequently as the simple solution of soft soap.

¹ R. <i>Picis mineralis</i>	3 i.
Glycerini (Price).....	3 iij.
Adipis benzoati.....	3 iss.

M. Or,

R. <i>Olei rusci purificati</i>	3 iss.
Zinci oxidi,	
<i>Olei amygdalæ</i> ,	
Adipis benzoati.....	āā 5 ss.

Olei rosæ..... ℥ij.

M. Sig. Melt a little and rub firmly into the seat of the eruption two or three times daily.

² J. Sellers & Co., 115 Bunhill Row, London, E. C.

³ W. V. Wright & Co., 11 New Fish Street, London, E. C.

In private practice, where expense is less an object than the elegance of the preparation, oil of cade may be substituted for common tar, and rectified spirit for methylated spirit, while a little oil of lavender may be added to conceal in part the disagreeable odor;¹ or, instead of using soft soap at all, a solution of potassa fusa may be added to the mixture, the amount of the caustic potash depending upon the amount of infiltration of the skin, and the extent of surface to which it has to be applied.²

The worst of these lotions is that they produce a temporary but marked discoloration of the parts to which they are applied, and if the eruption is situated on uncovered parts, and especially on the face, this is a serious inconvenience, and indeed some patients refuse to employ them on that account.

Further, it not uncommonly happens that they prove too stimulating, and then they have a tendency to aggravate instead of to remove the eruption. It was therefore very desirable to find out some way of altering their color, and of diluting them, and the difficulty was to produce a mixture capable of forming an emulsion with water. This can be done, I find, by mixing mineral tar and spirit in certain proportions, and by adding a little strong solution of ammonia, as in the formula which is appended.³ Such a mixture forms a yellowish emulsion with water in all proportions, and hence we can dilute it as little or as much as we please. The mixture sold by Messrs. Wright & Co. under the name of "liquor carbonis detergens," and which is stated to be a concentrated alcoholic solution of the active principles of coal tar, has probably a somewhat similar composition. It is a very excellent preparation, but is more expensive than that to which I have just alluded.

- ¹ R Saponis mollis,
Spiritus rectificati,
Olei cadini. āā ʒ i.
Olei lavandulæ ʒ iiss.

M. Sig. Rub a little firmly over the eruption night and morning, and wash it off before each re-application.

- ² R Potassæ fusæ gr. ix.
Spiritus rectificati,
Olei rusci,
"Eau de Cologne" āā ʒ i.

M. Sig. Sponge the parts night and morning, and whenever itching is troublesome.

- ³ R Picis mineralis. ʒ ij.
Sp. rectificati. ʒ ij.
Cola et adde,
Liquoris ammoniæ fort. ℥ viij.
Glycerini (Price). ʒ vi.
Aquæ destillatæ ad ʒ xij.

M. Sig. Sponge the parts two or three times daily.

I have been informed by Mr. J. Wheeler, Pharmacist, Ilfracombe (England), that he has recently discovered that by the addition of *lamina saccharina* (Sea Belt)—as prepared by him—to *pix liquida*, it is miscible with water in all proportions.

It is only very recently that *carbolic acid*, which is obtained from "coal-tar oil by fractional distillation and subsequent purification," has been employed in the treatment of disease, and indeed even now it is used principally as a disinfectant and antiseptic. There can be no doubt, however, that it possesses many valuable properties, and that it is destined ere long to play a much more important part in the therapeutics of skin diseases.

I have had many proofs of its value in the management of eczema. As an external application it is best to employ it in solution, as in the appended formula,¹ but the strength of the mixture must depend upon the degree of chronicity of the skin disease. It removes at once the fetid odor which often exhales from eczematous surfaces, counteracts the itching, and sometimes heals up the excoriations and ulcerations with remarkable rapidity.

If I were to compare the value of carbolic acid, of which I have had a comparatively short experience, with that of the tarry preparations just referred to, and with the virtues of which I have long been intimately acquainted, I should be inclined to say that the former is decidedly inferior to the latter, as a rule; but that it *may* succeed when tarry preparations have failed, and that it is also sometimes to be preferred, owing to the aqueous solution being quite colorless when fresh, and exhaling an odor which to most persons is neither pungent nor otherwise disagreeable.

The preparations of MERCURY are sometimes of service in the treatment of eczema, especially when the eruption is verging upon a cure, when the infiltration and exudation are gone, and the itching moderated, although in many cases it is difficult to say how much of the benefit derived is due to the unctuous substances with which they are usually combined and how much to the mercurials themselves; for unguents do good in cases of eczema, apart altogether from the active ingredients which they contain. They are not to be compared for one moment with the tarry preparations, unless a decidedly syphilitic taint lies at the root of or complicates the disease.

℞ Acidi carbolici cryst.....	℥ ij.
Glycerini (Price)	℥ i.
Sp. vini rectificati.....	℥ v.
Olei rose.....	℥ i.

Solve. Sig. Sponge the parts night and morning, and when itching is complained of.

Any of the ointments of the British Pharmacopœia may be used, as the unguentum hydrargyri ammoniati, nitratis, oxidi rubri, iodidi rubri, or subchloridi; or the mercurial preparations which enter into their composition may be given in a more concentrated or diluted form,¹ according as the parts require much stimulation, or are irritated thereby. If itching is complained of, a little cyanide of potassium, camphor, carbolic acid, or the like may be added, as in the subjoined prescriptions.²

If a lotion is preferred, from one to four grains of the bichloride of mercury may be dissolved with the aid of a little alcohol and mixed with an ounce of rosewater, while a little dilute hydrocyanic acid may be added if necessary, the solution being applied to the part two or three times daily.³ In using mercurial preparations locally, one must always bear in mind the possibility of their being absorbed in sufficient quantity to produce salivation; hence care must be taken in anointing an extensive surface, and the patient should be warned to discontinue the application if the gums become tender.

Some time ago I ordered a lotion of bichloride of mercury (gr. ij. to the ℥ i. of water) to be applied to the nose of a lady, and in three days, to my astonishment, salivation had occurred. On the other hand, I have repeatedly ordered stronger lotions to be applied to extensive surfaces for weeks without the occurrence of the slightest tendency to salivation, thus showing the peculiarities of different constitutions.

THE PREPARATIONS OF SULPHUR are of doubtful utility in the treatment of this complaint, unless the patches are in a very chronic state, and even then many of the applications previously referred to are much

¹R Hydrargyri bi sulphureti,

Hydrargyri citrico-oxidi levigati āā gr. vi.

Creasoti..... ℥ij.

Adipis recentis ℥ i.

M. (Startin.)

²R Hydrargyri ammoniati..... ℥ i.

Adipis benzoati,

Glycerini amyli..... āā ℥ vi.

Acidi carbolici..... ℥ i.

M. Sig. Apply two or three times daily.

Or,

R Liquoris carbonis detergentis..... ℥ i.

Ung. hydrargyri nitratis..... ℥ ij.

Ung. simplicis ℥ iv.

M.

³R Hydrargyri perchloridi gr. xij.

Acidi hydrocyanici dil ℥ ij.

Glycerini (Price) ℥ ij.

"Eau de Cologne"..... ad ℥ vi.

M. Sig. Sponge the parts two or three times daily.

more effectual. If, however, the eczematous eruption is brought out by the nails of patients whose skins are itchy owing to the presence of pediculi, or to their being affected with scabies, sulphur is useful in so far as it kills the parasites and removes the cause of the irritation; and thus this remedy often gets the credit of curing eczema, when, in point of fact, it merely removes the cause. Indeed, the eczematous eruptions complicating parasitic diseases are often aggravated for a time by the use of sulphur, although they may be ultimately benefited, owing to the cause of the scratching which produced the eruption being allayed.

While emollient ointments, which depend almost entirely upon their oily ingredients for their beneficial effect, are best supplied spread upon rags, stimulating ointments should, as a rule, be melted on the point of the finger, and rubbed firmly into the affected part, and none should be allowed to lie undissolved upon the skin, nor, in most instances, should their color be perceptible after their application; the surface should merely have the appearance of having been recently moistened. The part may occasionally be cleaned with white of egg and soft tepid water (rain water, if possible), for if layer after layer be smeared upon the skin it becomes rancid, acts as an irritant, and is calculated rather to be prejudicial than otherwise.

It is of the first importance, if ointments are prescribed, that the physician, unless he has perfect confidence in the apothecary who prepares them, should examine them before they are used; for if they are carelessly prepared, or if they are in the least degree rancid, as happens in innumerable instances, they are very apt to aggravate the symptoms which they were intended to allay. Hence the disrepute into which many valuable ointments have undeservedly fallen.

Astringents are of use in some cases of eczema, such as the sulphate of zinc or copper in proportions varying from three to twenty grains in an ounce of rose water, or the solution of the diacetate of lead, diluted with distilled water, or Dr. Shoemaker's ointment of the oleate of copper, which is obtained in a manner similar to that of the lead oleate by double decomposition with a saturated solution of copper sulphate. The washed precipitate melted with either four or nine parts of cosmoline, fat, or lard, gives respectively a ten or twenty per cent of oleate of copper ointment. I rarely use these medicines, however, believing them to be generally inferior to many others.

Persons who have very tender skins, or who are subject to attacks of eczema, should be careful as to what kind of soap, as well as to what kind of water they use for washing. Hendrie's "Dispensary Petroleum Soap," Pear's "Hospital Transparent Soap," Rieger's "Glycerin Soap" (warranted to contain forty per cent of glycerin), Price's "Solidified Glycerin" (said to contain half its weight of glycerin), and the "Sapo

carbonis detergens" of Wright & Co. (already mentioned) are amongst the safest and pleasantest toilet-soaps with which I am acquainted.

The following case of eczema erythematodes is of value, as illustrating many of the points of treatment to which I have adverted when the eruption covers an extensive surface :

"A gentleman from the West of Scotland, aged about forty, consulted me, on November 9, 1861, with regard to an eczematous eruption of great severity, and of many weeks' duration. (He had one previous attack which lasted three years.) The parts affected were the neck, lower part of the abdomen, inner aspect of the thighs, and the arms and legs, especially the flexor surfaces of the elbows and knees. The eruption was bright-red, and presented an erythematous surface, neither vesicles, pustules, nor papules being visible. There was no exudation from the abdomen or extremities. The skin of the neck, on the other hand, was much infiltrated, and from it serum exuded in abundance. The itching was severe. He was robust, without being corpulent, and, with the exception of the eruption, was to all appearance in perfect health. He was ordered to rub the inflamed parts firmly morning and evening with a piece of flannel dipped in a solution of soft soap, with the addition of a few drops of dilute hydrocyanic acid.¹ Cold water was frequently dashed over the parts, and five drops of Fowler's solution thrice daily after food, and a farinaceous diet were recommended.

"November 12. No change. Local application omitted, being too weak. The whole eruption was painted with a solution of potassa fusa (3 ss. to the $\frac{5}{8}$ i. of water), which was washed off with cold water whenever the smarting became very severe. This was followed by the exudation of a considerable quantity of serum, especially from the neck. The patient was ordered to repeat this every two or three days, oftener or seldomer, according to the severity of the application and the effect produced. The cold shower-bath was to be used twice daily, and the Fowler's solution to be continued.

"In a letter, dated November 21st, I was informed that the infiltration had quite disappeared from the arms, legs, and abdomen, and only some redness and itching remained. The infiltration, exudation, and itching of the neck were much moderated. He was ordered to continue the potassa-fusa solution to the neck, and a mixture of oil of cade, soft soap, spirit, and dilute hydrocyanic acid was to be rubbed firmly over the parts night and morning.² The Fowler's solution, which agreed, was to be increased to seven and a half drops thrice daily. The bowels and kid-

¹ B. Acidi hydrocyanici dil. ℥ xl.
Saponis mollis $\frac{5}{8}$ iss.
Aquæ destillatæ..... $\frac{5}{8}$ ij.
Olei rosmarini..... $\frac{5}{8}$ i.

² B. Acidi hydrocyanici dil. ℥ xl.
Olei cadini..... $\frac{5}{8}$ i.
Saponis mollis..... $\frac{5}{8}$ ij.
Olei rosmarini $\frac{5}{8}$ iss.
Sp. rectificati..... ad $\frac{5}{8}$ v.

neys being torpid, a teaspoonful of a powder containing sulphur, magnesia, and acid tartrate of potash, was to be taken at bedtime.

"On December 6, patient stated:—'Since I last wrote, the complaint spread down the legs to the ankles. I have thus been affected from the ear to the foot, first and last. The strong application (potassa fusa, ʒ ss.; aqua, ʒ i.) checked the inflammation, and no exudation took place.' The previous eruption he stated to be rapidly disappearing under the influence of the local applications, although the itching was considerable at times.

"On December 30 only a little roughness and very slight occasional itching of the skin remained. An ointment containing cyanide of potassium, benzoated oxide of zinc ointment, and citrine ointment, was to be applied night and morning.'

"On January 9, 1862, the patient came to see me. The eruption was gone, and there was only a feeling as if the skin was not so elastic as natural. The local treatment was omitted, the dose of Fowler's solution diminished to five drops thrice daily, and the purgative powder was only to be taken to relieve constipation.

"January 1, 1863.—No return of the eruption. Treatment omitted ten months ago."

There can be no doubt that the local treatment was the most effectual in this case.

(To be continued.)

Society Transactions.

NEW YORK DERMATOLOGICAL SOCIETY.

137TH REGULAR MEETING, MAY 22, 1883.

DR. E. B. BRONSON, *President, in the Chair.*

DR. FOX exhibited

A CASE FOR DIAGNOSIS.

Ten years ago, the patient, a man aged sixty-one years, noticed "a soft raised lump" at the left angle of his mouth. This was cauterized and destroyed, leaving a long linear cicatrix running along the outer edge of the moustache, concealed by the hairs. Two years ago, a lesion similar to the present one appeared, but subsided entirely under internal treatment with arsenic, as he states. It reappeared in the same situation three months ago. It is seated in the free border of the upper lip, to the right of the median line, is sharply defined, about the size of an almond, of a bright-red color, of a semi-cartilaginous consistence, and covered with a number of fine blood-vessels. It has never ulcerated, nor has

¹ R Cyanidi potassii gr. xij.

Unguenti zinci,

Unguenti hydrargyri nitratisāā ʒ i.

M.

it caused pain. He states that he had a chancre thirty-five years ago, but can recall no other lesions indicating syphilis. His general health is good.

He has been taking the "mixed treatment" for three weeks, and the lesion has now diminished at least two-thirds in size.

DR. TAYLOR said that he thought the case a very interesting one, but would prefer to express no positive opinion as to the nature of the lesion. Thickening and swelling of the lips might be due to a variety of causes. He had at present under his care a child whose upper lip had been much swollen for some time past. Noticing that the upper teeth were extensively decayed, he caused them to be extracted. This and the use of an astringent application had been followed by the disappearance of the swelling. A simple enlargement of the lips without lesion is often met with in strumous children. Another form of swelling is due to inflammation of the labial muciparous follicles, the lips often becoming glued together during the night. The only cure for this form of disease was, he thought, the ablation of the mucous membrane.

DR. SHERWELL thought the lesion a syphilitic gumma, his opinion being based mainly on the results of treatment.

DR. FOX said that when he first saw the lesion, it bore a marked resemblance to certain epitheliomata which he had seen on the lower lip. It was not indurated, but its shape was very much like that of an epithelial growth. The recurrence of the disease at two distinct points of course speaks for its specific nature.

DR. SHERWELL exhibited a

CASE OF MACULAR AND TUBERCULAR LEPROSY.

The patient was a native of China, twenty-seven years of age. He had never lived anywhere save in China and the United States. He is now under the care of Dr. J. F. O'Connell, of Brooklyn. The eruption first appeared on the face fifteen months ago, and is of a macular and tubercular character. It is now most marked over the face, neck, and extremities. The patient has had a number of erysipelatous attacks, which are all followed by increase in pigmentation of the parts affected. The skin of the face is much thickened, and there is marked induration and enlargement of the ulnar nerves. He complains of great lassitude and inability for exertion. The extremities are somewhat anæsthetic, and the patient tires easily on walking. These symptoms have much increased during the past four months. No bullæ have ever formed on the body. No history of heredity can be obtained from him, but he admits having had a chancre years ago.

DR. TAYLOR exhibited a

CASE OF DERMATITIS EXFOLIATIVA.

The patient was a boy of nineteen, of American parentage and birth. His family history is bad, lung-diseases having caused the death of many relatives. In January last, he contracted a sore on his penis, and gonorrhœa, followed by epididymitis and urethral fistulæ. About two months ago, he noticed a slight scaliness on his wrists, which soon extended to his face and chest. The skin felt hard and dry, but did not itch. The scaliness soon spread over the whole body. At the present time, there is a moderate thickening of the skin on either side of the neck, and some moisture is observed at those parts. Over the abdomen and chest are the remains of what seems to be a syphilitic eruption, in the forms of flattened tubercles and papules, of a much darker color than the skin in general. The hair of the head is very scanty, and the scalp is covered with scales. The patient is much emaciated, and presents marked anæmic appearance, the whole body, especially the abdomen and chest, being covered with scales, usually of arge size, which easily fall off, and the skin is everywhere decidedly pigmented.

The lunulae of the nails are also affected, being wrinkled and thicker than natural. The patient states that his bed usually contains a large quantity of scales after he has been in it for some time. The skin is but little thickened, and there is not much pruritus, except in axillae.

DR. FOX thought the case one of general squamous eczema, dependent probably in the first place on malnutrition, and secondarily on syphilis.

DR. SHERWELL thought the disease an unusual form of syphilis. The peculiar alteration here present in the matrices of the nails he had frequently seen in other cases, which had yielded promptly to antispecific treatment.

DR. BRONSON said that there could be no doubt but that the patient had syphilis; but the squamous disease was not, in his opinion, of that nature. The man has also true eczema in certain places. He did not think it a case of dermatitis exfoliativa, in which disease the scales are very thin and fine, and much more abundant than in this case. He thought it a case of seborrhoea, having noticed that there was an abundance of stearine in the scales. The congestion of the skin also speaks for that disease, which often occurs in cachectic persons. The affection of the nails he believed to be due to syphilis.

DR. TAYLOR thought that the fact that the scales were unusually abundant on the palms and soles, in which parts there are no sebaceous glands, proved that the case was not one of seborrhoea. The eczema on the neck he thought a simple complication, and not a part of the original disease.

DR. BRONSON said that the masses of scales on the feet did not, in his opinion, forbid the diagnosis of seborrhoea, which is not a disease of the sebaceous glands, but of the general cuticle.

DR. TAYLOR exhibited photographs of

A CASE OF KELOID FOLLOWING SYPHILIS.

The patient, a woman thirty-one years of age, is the mother of four children. The history of her syphilis is uncertain in its early period. Five weeks ago she had scabs in her hair and alopecia. On entering the hospital, she had a papulo-tubercular rash over the body, and mucous patches in the throat. The latter have annoyed her greatly for a month past, so that she could hardly take food. Four months ago, she had laryngitis, and a papulo-crustaceous syphilide, consisting of large lesions, appeared over the back and limbs, being scanty on the anterior aspect of the body. The crusts covered deep ulcers, which existed about two months, and then healed under treatment, the crusts falling off, and leaving thick cicatrices. During the evolution and course of this eruption, the nutrition of the patient was very poor. In addition to "the mixed treatment," she was given cod-liver oil and extra diet. During the past two months, the cicatrices have all become much thicker, while those over the back have become decidedly keloidal in character. On the front of the body, there are at present scarcely any lesions. The anterior aspects of the thighs are spared, but the cicatrices are numerous on the outer aspects of the legs. The keloidal lesions are scattered over the whole back and buttocks, over the left of which is a large, deep gummatous ulcer. On the legs, the cicatrices are much paler in color when she is lying down, and assume a deep bluish-black tint when she stands up. Here they are gnarled in character, but not keloidal. The keloidal lesions are largest and most abundantly developed over the scapulae and humeral regions. They are elevated about two lines above the skin, generally rising abruptly from it, are of a vivid pink color, and many fine veinules can be seen on their surfaces, sometimes running in their long axes, and sometimes jutting laterally into them from the surrounding skin.

In his experience, keloid after syphilis was neither a common nor a very rare affection, he having found it in one-half to one per cent of all his cases. He had seen the greater part of the body covered with ulcerative and non-ulcerative

lesions, and yet no keloidal growths. In other cases he had observed it over the shoulders, chest, back, and knees. He had never seen it over the subcutaneous portion of the tibia. The development was most common over the back, where the tension was greatest, and the fascial and fibrous bands thickest, and most abundant. The subjective symptoms were unusually prominent in this affection. This patient complains of terrible itching in the keloidal masses at night. The sensations vary from pruritus to gnawing, burning, and fulminating pains, of the most severe character. He recalled the case of a lady with one large keloidal growth following syphilis, over the fourth lumbar vertebra. It caused her indescribable agony, the pains coming on at night and being always intensified by the use of stimulants. They were finally caused to disappear by destroying the mass with caustic potash.



DR. MORROW had never seen a case in which the development was as precocious as in this. He had had three cases of the disease under observation, and in all of them the subjective symptoms were prominent features. In one case, in which the keloidal growths have been in process of development for nearly a year, one of the lesions is situated on the flexor surface of the elbow, two others on the shoulders, and a number on the back, but none on the anterior surface of the body. In this case, as in two others under his care, the pruritus was a very marked and distressing feature of the disease. In these cases, the color of the lesions was far less vivid than in the colored photograph shown by Dr. Taylor.

DR. FOX asked whether there were any cicatrices on the body of Dr. Taylor's patient which were of traumatic origin. He thought it of interest to ascertain whether in such cases there was or was not an intrinsic tendency to keloidal for-

mations after other than syphilitic lesions. He had seen a great many hypertrophic cicatrices following syphilis which had been called keloid, but did not deserve the name. Dr. Taylor's case was evidently not one of this kind. He himself had never seen such an extensive keloidal formation after syphilis. In a certain proportion of cases of syphilis the cicatrices become elevated, and present a slight resemblance to keloid, but the skin remains white and hard, being itself the principal seat of change, whereas in keloid the corium is thin and almost normal, the fibrous deposit taking place beneath it. In the ordinary hypertrophy of cicatrices the epidermis seems thickened, and there is a hard, board-like condition of the mass. The development of blood-vessels on the surface, seen in Dr. Taylor's photograph, occurs only in keloidal growths. He was inclined to believe that the lesions in the case would disappear in time, as true keloid never did.

DR. TAYLOR said that there were no evidences of injury on the woman's body. He had seen fibrous bands and scars after syphilis in six cases, but could not recall any subjective symptoms in connection with them. Keloidal growths are more succulent and hyperæmic than ordinary cicatrices, and it seemed to him possible that this recurring hyperæmia might in some way be associated with the pain. As regarded their etiology, he thought that the facts that the woman was originally delicate, and was much more debilitated by the syphilis, and that most of the growths were seated on the back, where the greatest pressure prevailed, should be taken into consideration.

DR. TAYLOR read notes of cases of

PAIN ACCOMPANYING INITIAL LESIONS IN WOMEN.

A lady aged thirty-four years contracted syphilis from her husband. She came under his care six months ago, having an extensive parchment-like chancre, with a tenacious diphtheritic deposit on the fourchette, extending upon the posterior wall of the vagina. The peculiar feature of the case was the excessive pain, which began on the fourteenth day from the appearance of the chancre, Stimulating and soothing lotions of different kinds, iodoform and morphia combined, all failed to give relief. Even morphia suppositories did not make the patient comfortable. As a last resort, he burned the chancre with a saturated solution of caustic potash, and only produced relief after three applications, followed by very hot injections, and stuffing the vagina with absorbent cotton saturated with lead and opium wash. The second case was a lady twenty-one years old, who contracted syphilis from her husband. She had, when first seen, a few months ago, an immense induration of the clitoris and its prepuce. The organ was as large as an index finger and as firm as cartilage. At its tip was a greenish, foul ulcer. The sufferings of this patient were simply terrible. She had no rest day or night, and opium was powerless for her relief. Iodoform and morphia, hot water stupes, lead and opium wash, strong solutions of carbolic acid, all failed. Then, remembering his success with the previous case, he cauterized the ulcer with the potash solution, and applied lead and opium wash. The result was most favorable, as the patient was relieved of all pain. Mauriac, in his recently published "*Leçons sur les maladies vénériennes*," Paris, 1883, speaks of the pain which sometimes attends chancres of the clitoris. He had had a case of this form of chancre recently in Charity Hospital, in which the pain was very severe. His explanation of this pain was that, when the ulceration occurs in spots which are peculiarly rich in their nervous supply, as at the clitoris and fourchette, the irritation of the ends of the nerves gives rise to the horrible suffering which he had spoken of.

He had never noticed pain in uncomplicated chancre in the male, but only when phagedæna or balanitis was present.

DR. TAYLOR also read notes of

A CASE OF GUMMOUS BURSITIS.

The patient, a man thirty-two years old, had syphilis six years ago, and was indifferently treated. About one year ago, he had a gummatous ulcer of the size of a quarter of a dollar on the right thigh. This healed under the "mixed" treatment," and, after two months' medication, the patient became careless. Five months ago, he came with a firm swelling over the right outer malleolus. Three months ago, he came with two symmetrical tumors, one over each trochanter major, about one inch in width and two in length, firm, hard and painless, the skin being freely movable over them. They were situated at right angles to the axis of the legs. They are now rapidly subsiding under "mixed treatment."

The Society then went into executive session, and the following were elected officers for the ensuing year: *President*, Dr. P. A. Morrow; *Secretary*, Dr. W. T. Alexander; *Treasurer*, Dr. F. D. Weisse.

The Society then adjourned until the fourth Tuesday in September.

[The Editors desire to express their acknowledgments to Dr. Alexander for the faithful and admirable reports of the meetings of the Society that have appeared in the columns of this JOURNAL.]

Selections.

THE QUESTION OF CONTAGION IN LEPROSY.

In the earliest times and during the medieval ages leprosy was considered and treated as a contagious disease. But when, by the practice of seclusion, rigidly enforced during many centuries, the disease had nearly died out in Europe, men became ready to accept any positive doctrine concerning its etiology put forth by individual observers or scientific bodies. Thus it has happened that during the present century the opinion has been almost universally adopted by the medical profession that leprosy is not contagious, and that it is endemic mostly because it is hereditary. There have not been wanting, however, observers who have stoutly combated this exclusive doctrine, and who claim that the facts which point to the contagious character of the disease have been neglected or misinterpreted. The many other causes which have been assigned are so diverse and contradictory that they call for no consideration. The theories of heredity and contagion, however, are not incompatible, they support each other. We have an illustration of such an etiological relation in syphilis. The important point to be determined is the proof of the latter, not the disproof of the former. Fortunately for the solution of this question we have in the recent introduction of leprosy into an insular nation (Hawaii) and in several freshly developed foci of the disease upon our own continent (New Brunswick, Cape Breton, Northwestern States, South Carolina, Louisiana, California, and Oregon) that virgin field for observation so essential for the proper study of this subject. The lessons drawn from the data thus supplied seem to be confirmed by the teachings of history—and these lessons, or deductions, appear to justify the following conclusions:

Leprosy has spread under recent observation, when introduced into a previously unaffected stock, in so rapid and general a way as to prove that it may

diffuse itself universally through a nation, independently of the action of hereditary tendencies. There is no evidence to support the assumption that this wide and quick extension of the disease has been caused or aided by any peculiarity of soil, climate, diet, or other telluric agency in Hawaii. The history of the affection, on the other hand, leads to the strongest conviction (scientific proof is well-nigh out of the question) that it is communicated directly from person to person, while the peculiar customs offer a satisfactory explanation of its unparalleled spread. The history of the little centre of disease in Louisiana, watched fortunately from its very beginning, leads to the same conclusion that it affects persons not under any law of heredity, but through the intimacy of personal relationship, the customs and morals determining largely the rapidity and universality of its spread. So, too, syphilis abstracted from its venereal relationships, could exist as a disease, and does communicate itself in no inconsiderable measure in various other ways. It is only through the assistance of the loose sexual customs of certain grades of the population everywhere that it has become such a world-wide pestilence. Take away from it its characteristic initial lesion and give it a greatly prolonged incubative stage, and the difficulty of determining the circumstances of inoculation would be as great as in the disease we are considering.

It is probable that leprosy may, like syphilis, be communicated under all circumstances by which some of the fluids and other products of the infected foci of a diseased person come in contact with abraded or excoriated, possibly with the uninjured surface, of a healthy person. It would be necessary that the diseased products should be at the surface of the skin or mucous membrane, and this would generally be accomplished during the process of softening by which the impermeable epidermal layers were removed. Thus the nodular form in its ulcerative stage would necessarily be the most dangerous phase of disease, whereas the anæsthetic form might exist for years with little danger of communicating itself to its surroundings. In this sense we may conclude that leprosy is contagious, and in these ways, probably, the disease mostly spreads in a family, a community, a nation. Hereditary transmission need not be excluded as a direct cause in individual cases, although as to how largely the disease originates in this way and how remotely such influences may extend, our exact knowledge is very deficient.

But if contagious, what is the contagious element in the disease? A constitutional virus peculiar to it, or a foreign organism, an entophyte, which is the sole cause of the local tissue changes and indirectly of the subsequent systemic changes? The latter theory offers, apparently, the most satisfactory explanation of the peculiar features of the affection, while of the actual existence of the so-called *bacillus lepre* in the various tissues of the disease there can be no doubt, and but little as to its nature. *A priori*, there is no reason why the bacterium found may not satisfactorily explain all the local and general pathological processes characteristic of the disease, and it has been found in connection with cases from so many parts of the world and by so many reliable and experienced observers, and has, under all circumstances, presented so uniformly identical appearances that the probability of such specific relationship grows stronger and stronger. The results of inoculation are as yet negative.

If, then, we are prepared to admit the contagious nature of leprosy, what measures should be taken for its exclusion from and repression within the country? We have at present an unknown number of lepers in the United States, let us say fifty or a hundred; three undoubted centres of contagion, affecting three entirely distinct nationalities, in different climates, and under quite

diverse methods of living. It is evident that the disease may make more rapid advance in one part than in another. Any circumstance, for instance, which tends to soften or abrade nodules, as a hot climate possibly, would of course greatly increase the danger of infection, so that the necessity of interference by compulsory means might be more urgent in the former than in the latter. It is evident, however, that such measures should be undertaken by the national government, and that they should be made applicable to all parts of the country alike. These measures should be the establishment of graded hospitals in possibly insular localities in various parts of the country, to which all access should be prevented, excepting under restrictions determined by professional rules: the enactment of laws which should make residence compulsory and perpetual, and the concealment of the disease punishable by severe penalties. These rules should apply to so-called sporadic as well as to endemic and imported cases, but the latter should be given the option of returning to their native land. The immigration of lepers should be prohibited and arrested at ports of arrival by inspection so far as possible, as other contagious diseases now are by quarantine regulations. By the establishment of such national measures immigration from leprous countries would largely cease, lepers would no longer change their residence within the country to escape the action of local laws against their liberty: marriage with them would become abhorrent when the people had thus become aware of its dangers, and after a generation has passed the disease should be virtually eradicated.

Lepers belong to the dangerous classes of the community which require perpetual confinement, and the sooner this remedy is applied the less seeming cruelty will attach to it.—WHITE, *Amer. Journ. of the Med. Sciences*, October, 1882.

BUBO.

SOME authorities have supposed that the development of a bubo is influenced by the dimensions of the primary sore, but this is certainly not the case. The smallest chancroids may be succeeded by the most formidable buboes. The inguinal affection generally sets in within ten or fifteen days from the appearance of the chancre, but there are frequent exceptions to this rule, and a bubo is sometimes formed as late as a month or even two months after the chancre has completely healed.

The diagnosis of bubo is in many cases unattended with difficulty. While the abscess is still closed, its investing integument will be thin and of a livid hue—in short, it will exhibit signs of mortification from which the nature of its contents may be easily inferred. If it be laid open by incision, the edges of the wound will have an ulcerated appearance, and the whole anterior wall will be no thicker than a sheet of paper. If it breaks spontaneously, the abscess wall will present three or four sieve-like openings which will speedily enlarge and merge into one another, so that the bubo at last will take on all the characters of a simple chancre. In some cases this ulcer heals spontaneously, the pus discharges outwardly, the cavity closes, and the affection terminates like a non-specific bubo.

As to treatment. If pus has formed it should be evacuated at once by a free incision, after which, if the wound be properly attended to, healing takes place, in favorable cases, without further trouble. But more frequently the artificial opening, instead of closing, becomes larger, and the neighboring tissues are affected by the burrowing of pus. In this case, the abscess should be freely laid open by scissors, thus obtaining an exposed surface to which dressings can be

conveniently and effectually applied. The best local application is that of iodoform. Its only disadvantage is the intolerable odor it diffuses, which is sufficient to debar it from use in private practice, except as a final resort. In its stead, phenic acid may be employed, and the affected surface painted over with iodine every morning.

While simple bubo may be completely cured in fifteen days, the variety we are considering requires at least a month of treatment. Phagedena is its most formidable complication. This appears under three forms—pultaceous, inflammatory, and gangrenous. Each is marked by special features; but the results most to be feared in this connection are the production of hemorrhage and the breaking down of the constitutional forces. Thus, in one of our hospital patients this very year, a phagedenic ulcer which formed on one side of the sacrum laid bare the bone and brought on spinal meningitis, which soon terminated fatally.

Any debilitating influence may give rise to phagedena, but thus far we must confess that its exact mode of origin is inscrutable.

When thus complicated, the duration of a syphilitic bubo will be from three or four months to a year. A single case has been reported in which it lasted fourteen years.

SYPHILIS IN THE FAMILY.

THE propagation of syphilitic disease by means of the family relations may take place either directly or indirectly, the husband being usually the responsible party. In the former case, the infection is generally communicated, not through the primary lesions, but, after they have healed, through the mucous patches so commonly met with in the mouth and throat, or the eruptions which spring up around a cicatrized sore, before the appearance of secondary symptoms.

When a married man has contracted syphilis, his wife, unless proper precautions are taken, is inevitably condemned to share his misfortune. Marital relations should be absolutely interdicted during a month or two months, the husband observing the most scrupulous cleanliness in order to obviate any possibility of danger. Mercurial treatment should be energetically employed, and the cicatrization of the sore should be promoted by cauterizing with nitrate of silver, and even with the acid nitrate of mercury.

Marital intercourse, when the husband has had syphilis, and has temporarily recovered from the complaint, may be safely indulged in so long as it does not result in pregnancy. If this condition should supervene, and syphilitic symptoms should declare themselves in the wife within eighty days from the date of conception, she will have contracted the disease, not directly from her husband, but through the medium of the child which he has infected at the moment of procreation. No general rule can be laid down respecting the hereditary transmission of syphilis. The greatest danger in this direction is incurred when the father is affected with a fully-developed eruption of syphilitic roseola. Mercury exerts a favorable influence on this condition, and should always be resorted to during its existence, with the view of weakening the effect of the specific virus upon the offspring, in case conception should unfortunately take place.

The average length of time during which marriage should be forbidden to a syphilitic patient is three years from the appearance of the primary sore, that is, provided he is careful in his habits and receives rational treatment.

Syphilis is a frequent cause of abortion.

As specific lesions in the case of infants do not manifest themselves until twenty-five days to two months after birth, any suspicions which may be enter-

tained of ante-natal infection cannot be verified until these periods have elapsed. If the disease develops, mucous patches—scaly, coppered spots, changing from dry to moist—will appear about the mouth and anus. A specific coryza, remarkable in so young a child, will also set in, together with symptoms referable to the tongue, the bowels, the liver, the lungs, the brain, and the thymus gland, which run an irregular course and always terminate fatally.

The mother of a syphilitic child may nurse it with impunity. When two or three months old, it may be transferred to a wet-nurse, or goat's milk may be substituted for its natural aliment.

The treatment of infantile syphilis is an exceedingly delicate affair. Van Swieten's liquor (twenty drops in a cup of milk) should be administered daily, unless found to irritate the bowels. External treatment must then be resorted to, consisting of baths, and frictions over the groins and axillæ with Neapolitan ointment. A similar use of corrosive sublimate is sometimes advisable. Iodide of potassium is seldom indicated.

A woman should never be subjected to anti-syphilitic treatment during pregnancy unless she herself exhibits symptoms of specific disease.—MAURIAC, *L'Abeille Médicale*, August 21, 1882.

NAPHTHALINE AS AN ANTISEPTIC DRESSING.

THE fatal results that have been recently reported as of almost weekly occurrence from the use of iodoform in German hospitals have led surgeons to regard it with some distrust. Dr. Fischer (*Berlin. Klin. Wochens.*, No. 46, 1881, and Nos. 8 and 9 for 1882) recommended naphthaline as an antiseptic dressing, in lieu of iodoform, as possessing the advantages of the latter without its dangers. Adopting the suggestion, Dr. Anschütz used naphthaline in about ninety cases. This remedy was regarded by Fischer as possessing powerful antibacteritic and antiseptic effects, and as the more applicable to surgical uses because it is comparatively free from any toxic influence. This he considered to be due mainly to its insolubility in water, or in the discharges from the wound: hence it is impossible for absorption to take place from the surface of the wound. Dr. Anschütz enumerates among the advantages of naphthaline its very low price (about 12 cts. per pound) and the fact that it is used in powder, and is, therefore, much more convenient for transportation and use than the material required for the Listerian processes. On these grounds, he thinks that it will be found preferable in military surgery as a first dressing on the battle-field. It does not interfere with primary union, and causes no pain or irritation.

The jute employed by Dr. Anschütz, having been saturated with a ten-per-cent solution of naphthaline, was found to adapt itself admirably to the inequalities of the body and of the injured surface. No dressing was kept on longer than six days.

Whether because the naphthaline used was not a perfectly pure article, or through some mistake in applying the dressings, the results obtained by Anschütz did not conform exactly with those reported by Fischer. The operation of the naphthaline appeared to be too energetic in cases where the granulating process was healthy and vigorous, so that its use is only to be recommended when the sore is of a torpid and indolent character. In some cases, moreover, blood was mixed with the secretion, as if the crystals of naphthaline had injured the granulations; and, worst of all, in others the powdered naphthaline hardened into a tenacious crust which retained the discharges. On account of this last disadvantage, Dr. Anschütz is inclined to look upon this remedy as of doubtful

utility in military practice. Further experiments and observations are needed to establish its precise value.—*Centralb. f. Chirurg.*, Aug. 12, 1882.

THE ABSORPTION OF WATERY SOLUTIONS BY THE SKIN.

1. SUBSTANCES dissolved in water may make their way through the epidermis without producing any visible external lesion.

2. Nevertheless, the essential condition of such penetration appears to be a break in the epidermis where it is prolonged into hair-sheaths, and along the included portions of the hairs themselves.

3. In fact, according to our observations, this penetration takes place exclusively in hairy parts.

4. It is promoted by whatever causes the hair to be pulled about, as, for instance, friction with the moist or dry hand, or unusual size, stiffness, and length of the hairs.

5. A delicate integument and thin cuticle afford unfavorable conditions, on account of the less vigorous growth of hair on parts thus endued. Total absence of hair is likewise a condition eminently unfavorable to absorption.

6. Hence we may infer the possibility of introducing soluble substances into the circulation by causing them to penetrate the epidermis in small quantities, either with or without the aid of baths. To effect this, friction with the palm of the hand would have to be applied forcibly over a large surface, and especially where the skin is hairy. The only possible unpleasant effects would be a moderate degree of inflammation, manifested in a little redness and smarting about the roots of the hairs.

7. Simple immersion in a bath, however prolonged, could not be relied on to effect the entrance of even the smallest quantity of a solution through the skin.—AUBERT, *Annales de Derm. et de Syph.*, November 25, 1882.

ON THE SUBCUTANEOUS INJECTION OF AMMONIO-MERCURIO PEPTONES IN THE TREATMENT OF SYPHILIS.

1. THEY produce in no case any very severe pain—not even enough to cause that faintness which is so commonly experienced under the employment of any other preparation of mercury especially the biniodide.

2. They give rise to no inflammatory swelling, abscesses, or sloughing sores, even when performed on diabetic subjects. This was shown in the case of one of my patients whose urine contained sixty-nine grams of sugar to the litre (he passed about five litres of urine, containing 345 grams of glucose, every twenty-four hours), and yet, despite this enormous discharge of sugar, the hypodermic injection had not the slightest injurious effect upon his skin. This fact is sufficient to prove the harmlessness of the neutral solution of these peptones.

3. Salivation or mercurial stomatitis was very seldom observed, except when due to previously-existing irritation of the buccal mucous membrane, caused by tobacco, alcohol, morbid dentition, etc.

4. The gastro-intestinal disorders which so often accompany the administration of mercury by the mouth or by inhalation were never encountered, and consequently this method of treatment did not conflict with the employment of remedies suited to any constitutional or diathetic malady which might have preceded the syphilitic infection.

5. Hypodermic injections exert an action upon syphilis in all its forms and manifestations, whether normal or abnormal, at once more powerful, more be-

neficent, and more prompt than can be obtained by administering mercury or its compounds in any other way. Very many cases of abnormal, of dangerous, and of so-called malignant syphilis might easily be adduced from the records of both my hospital and my private practice, which would contribute to place the truth of this assertion in the most convincing light.—MARTINEAU, *L'Union Méd.*, Aug. 19, 1882.

NEW REMEDY FOR SYPHILIS.

PROF. LIEBREICH brought forward, at the last meeting but one of the Berlin Medical Society, a new drug for the treatment of syphilis by the subcutaneous method. This drug rejoices in the name of hydrargyrum formidatum, and is, therefore, merely a different form of the old cure for syphilis. The mode of its preparation was not stated; chemically, it belongs to the amide group, in whose structure the monovalent amidogen (NH_2) plays an important part. Liebreich was led to think of this new preparation from the notion that the ordinary amides of the body, of which urea may be regarded as the principal one, pass out of the organism in an undecomposed state; when, however, an amide is in combination with a metal, decomposition readily occurs, and the metal is reduced and deposited. Liebreich repeated his experiments before the Society, and showed that these conjectures were quite true for the metal mercury. It is supposed, therefore, that the formamide of mercury, after the hypodermic injection, undergoes disintegration; and so the mercury is set free, and is able to exert its well-known power over the lesions of syphilis. The preparation is easily soluble in water, is of neutral reaction, does not coagulate albumen, is not precipitated by caustic soda, and the presence of mercury can be demonstrated by means of sulphide of potassium. The drug, when injected under the skin, produces its effects very surely and rapidly. This is not regarded as a disadvantage, for the medicine is said to be easily borne, and has never produced salivation in Liebreich's hands. There is very little pain attendant on the injection, which has never excited any inflammation. From a half to a whole of a Pravaz syringeful (a one-per-cent watery solution) may be injected twice or thrice daily. Liebreich looks on the preparation as the best we yet have for subcutaneous injection.—*Med. Times and Gaz.*, January 6, 1883.

ITCHING CONSIDERED AS A SYMPTOM OF BRIGHT'S DISEASE.

1. During the course of Bright's disease, itching is experienced unconnected with any cutaneous eruption, and sometimes invading every portion of the integument.

2. This symptom may be described as occurring in three different forms: 1st, as itching, properly so-called; 2d, as horripilation; 3d, as formication.

3. These sensations are a frequent accompaniment of Bright's disease; they are complained of at various periods: they may be felt both at the outset and during the course of the confirmed malady.

4. When met with at the commencement, they rank as an important symptom and one of great semeiological value; they coincide, at this period, with the pollakuria, the cramps, the palpitations, the disorders of hearing, the epistaxis, etc., and may precede the appearance of oedema and albuminuria, thus serving, without any other aid, to place the physician on the right diagnostic track.

5. Coming on at a later period, they merely constitute an additional and conjoint symptom of the disease.

6. The pathology of this phenomenon is as yet based upon hypothesis. It

represents a disorder of the sensory sphere, due, probably, to the irritation produced at the terminal extremities of the nerves by refuse material retained in the blood through failure in the eliminative functions of the kidneys.—MATHIEU, *Th. de Paris*, 1882.

THE BOUTON D'ALEP.

1. THE *Bouton d'Alep*, in the light of our present knowledge, appears as a diffuse inflammation of the derma, due to a dermatophyte first discovered by Mr. Van Dyke Carter.

2. It may now be regarded as a scientific certainty that the names *Bouton d'Alap*, *De Biskra*, *Du Nil*, *De Delhi*, etc., designate merely different forms of one and the same morbid entity.

3. The affection is not contagious.

4. It is capable of inoculation, and may occur more than once in the same individual. Its active inoculable principle is seated in the scab.

5. By taking careful note of the patient's constitutional condition, the nature of his environments, and the course and development of the eruption, a correct diagnosis is easily arrived at.

6. Prognosis in this complaint is always favorable.

7. Treatment must be confined to local applications—constitutional measures being always unavailing—and to the proper management of any complications that may arise.—GALY-BRIULAT, *Th. de Paris*, 1882.

TREATMENT OF WARTS.

1. A WART on the sole of the foot, though in itself not a serious matter, is the source of constant and often excessive pain, almost crippling in its effects, and hence demanding surgical aid.

2. Despite the authority of Boyer and of Robert it has not been proved that a wart can form the starting-point of a perforating ulcer.

3. The occurrence of a cancerous degeneration in these excrescences, though affirmed by Leplat, Hebra, and others, has not been established by the evidence adduced.

4. The practitioner should always bear in mind the striking analogy which often exists between a wart and epithelioma in its incipient stage: if the patient has passed middle life, and if the wart is solitary and has not been preceded by similar growths elsewhere, equally energetic measures will be called for, as though the existence of cancer was undoubted.

5. Warts under the nails are accompanied by intense pain, and give rise to a kind of onychia requiring prompt and vigorous procedures.

6. The most efficacious treatment is by cauterization—after abrading the horny covering of the wart—with crystallized acetic acid or with Vienna paste.—CORNEAU, *Th. de Paris*, 1882.

ALBUMINURIA AS A CONSEQUENCE OF CUTANEOUS EXCITEMENT.

1. CUTANEOUS excitement, by whatever means produced, may give rise to albuminuria.

2. The amount of albumen which, in such a case, can be almost at once detected, will vary according to the degree of excitement, the energy of the exciting agent, the extent of surface acted on, and the duration of the excitement.

3. The duration of the albuminuria will also be determined by the same conditions; in most cases it is transient, but, under the influence of extreme peripheral irritation, it may persist, along with an alteration in the organic structure involved.

4. Albuminuria proceeding from cutaneous excitement depends proximately on a disturbance of vaso-motor innervation.—KÉMHADJIAN MIHRAN, *Th. de Paris*, 1882.

TREATMENT OF TINEA CAPITIS.

1. THE group of diseases (*herpes tonsurans*, *porrigo favosa*, and *porrigo decalvans*) comprehended under this title, being recognized as parasitical dermatoses, their rational treatment must, of course, be directed against the parasites. Two modes of procedure fulfilling this condition have been found preferable:

a. Epilation, which exterminates the parasites by destroying the organic structure in which they make their habitation.

b. The local application of croton tiglium, which accomplishes the same object by inflaming, without destroying, the derma and hair-follicles, and thus removing the infested hairs.

2. In cases not too inveterate, a cure or decided amelioration is usually obtained within a period varying from three to eight months, and after from three to five applications of the remedy.

3. Clinical experience has shown that this treatment is not followed by any special tendency to relapse.

4. As to the other unfavorable results which have been charged to the employment of this remedy, viz., intense folliculitis, inflammation of the scalp and even the occipito-frontal aponeurosis, and erysipelas, it is precisely these evils which the croton oil dressing, in the form recommended, is intended to avert. Neither the above symptoms, nor the alopecia which has been said to follow them, have been produced in any of our cases.

5. The only unpleasant consequences we have ever witnessed have occurred from the accidental transfer of the ointment to other surfaces, such as the conjunctiva, in which latter case a conjunctivitis might possibly arise: but this danger is easily obviated by protecting the scalp with a properly adjusted cap. We have never known such an accident to result in anything more serious than a slight conjunctival hyperæmia.

6. As to erysipelas, statistics show that it follows the croton treatment in an average of four cases out of a thousand, and that it has invariably been cured.

These risks are insignificant when measured against the extreme pain which epilation inflicts upon a child, and when also the inefficiency of the latter method is considered, since the hairs almost always break off under the operation.

7. To sum up our subject, the results of treatment by croton tiglium dressing may be pronounced highly satisfactory in *herpes tonsurans*, and encouraging in *porrigo favosa*, and in certain cases of *porrigo decalvans*.—MASSEY, *Th. de Paris*, 1882.

DARK SPOTS CAUSED BY THE PHTHIRIUS PUBIS.

AT a recent meeting of the *Société de Biologie*, M. Dugué read an interesting communication on the dark-colored spots on the skin which are caused by the phthirius pubis. Having frequently observed these spots both on diseased and healthy subjects, he arrived at the conclusion that they always denoted the presence of pediculi pubis, but that the pediculi were not necessarily accompa-

nied by the spots. M. Dugué conceived the idea that these spots were the results of inoculation with a specific virus secreted by the parasite. In order to test the correctness of his theory, he pounded a number of the pediculi in a mortar, and by inoculation with their residuum produced an eruption of spots similar to those originally observed. One of his pupils, M. Mallet, had since been engaged for several months completing this investigation, in the following manner:

Having torn off the head of one of the animals with a pair of fine forceps, he introduced it under his own skin, the body being inserted in the same way at a point not far distant. Next day, a spot made its appearance in the latter situation. After repeating the experiment under every possible condition, MM. Mallet and Dugué concluded that the poison-glands which gave rise to the spots in question were situated on the thoracic region of the parasite. This agrees with the observations of M. Landois, who has described certain glands as existing on the sides of the cesophagus of the phthirius pubis, and as capable of discharging their contents through the creature's mouth.—*La Tribune Médicale*, August 13, 1882.

TREATMENT OF SCABIES BY NAPHTHOL.

I. THAT naphthol is a parasiticide is abundantly proved by its employment against scabies and phthiriasis in man and *l'acariasse auriculaire* among dogs.

II. Naphthol-ointment, as prescribed by Professor Hardy, is applicable at any of the stages of scabies, whether simple or complicated.

III. The same remedy is rapidly efficacious against the prurigo of scabies, without producing the smarting sensation which generally follows the use of Helmerich's ointment.

IV. Naphthol-ointment is also of service against those eruptive sequelæ of scabies in which Helmerich's ointment is usually contraindicated.

V. The average duration of the Naphthol treatment of scabies is from ten to fifteen days.

VI. The employment of M. Hardy's preparation has occasioned no bad results whatever, either as respects the skin or the internal organs, especially the kidneys.

VII. Naphthol-ointment possesses, moreover, some accessory advantages; its odor is agreeable, and it does no harm to underclothing or bandages.—GUERIN, *Th. de Paris*, 1882.

REMOVAL OF A TIGHT RING FROM THE FINGER.

A NOVEL method of effecting the removal of a ring which has become constricted around a swollen finger, or in any other similar situation, consists simply in enveloping the afflicted member, after the manner of a circular bandage, in a length of flat, India-rubber braid, such as ladies make use of to keep their hats on the top of their heads. This should be accurately applied—beginning, *not* close to the ring, but at the tip of the finger, and leaving no intervals between the successive turns, so as to exert its elastic force gradually and gently upon the tissues underneath. When the binding is completed, the hand should be held aloft in a vertical position, and in a few minutes the swelling will be perceptibly diminished. The braid is then taken off and immediately reapplied in the same manner, when, after another five minutes, the finger, if again rapidly uncovered, will be small enough for the ring to be removed with ease.—LANGON, *Gaz. des Hôp.*, September 9, 1882.

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ON HERPES PROGENITALIS, ESPECIALLY IN WOMEN.

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I DO not think that I can more appropriately contribute to the pages of the JOURNAL OF CUTANEOUS AND VENEREAL DISEASES than by continuing a discussion which took place at the fourth annual meeting of the American Dermatological Society, at Newport, Aug. 31 to Sept. 2, 1880. Dr. White read Dr. Greenough's paper on herpes progenitalis, in which occurs the following passage on the distribution of of this affection, so common in both sexes :

"Sex.—Almost all writers state that the female genital organs may be the seat of herpes progenitalis, but I find no case reported. I have never seen but one, in that there were five or six ulcerations on the inner surface of one of the nymphæ, but I do not feel at all sure that it was not more properly a condition analogous to balanitis. There were considerable local congestion and œdema, and in three days the part was normal." In the following discussion, Dr. Bulkley remarked "that he was much interested in the question of the occurrence of herpes progenitalis in females, especially the statement of its non-existence. He had certainly met with it in women more than once, and was not at all prepared to

receive the statement, that the writer has not seen it. He requested the views of other members upon the subject."

Dr. Duhring, replying to Dr. Bulkley's questions, said that he had never encountered a case of herpes progenitalis in the female.

Dr. White suggested that its rare occurrence in females might be explained by the fact that it may pass unnoticed, as it does not occasion much annoyance, and being in a less exposed situation, is much less likely to attract attention.

Dr. Heitzmann said: "that in the large atlas of Hebra, there was a good representation of herpes progenitalis in the female. It was not a case of herpes zoster."

After reading the above quotation from Dr. Greenough, I was much astonished, because within four years I had met with at least two hundred cases, and possibly more, of herpes progenitalis in females. However, my astonishment was increased by the assertions of Dr. Duhring, who, despite his immense experience, claimed never to have met with a single such instance. Considering all this, it seems to me not at all unimportant to draw attention to this subject in this JOURNAL, at the same time attempting an explanation of the striking difference of opinion respecting the frequency of its occurrence.

Geographical and national differences as an explanation I discarded at once; not only because the experience of gynecologists in large practice here (Hamburg) coincided with that of my American colleagues, but also because my experience in private practice during the last few years was the same. It was therefore plain that my considerable experience of herpes progenitalis in females was owing to an essentially special field of observation; and it of necessity followed that difference of opinion here is due to the difference existing in the character of the clinical material observed. My experience referring to this subject was derived from a four-years' service as official examiner of *puellæ publicæ*. I am sure that every physician who has control of such individuals in a hospital, wherever it be, or who is concerned in the surveillance of prostitution in cities, will have an experience at least equal to mine in this disease; whilst, on the other hand, dermatologists and gynecologists everywhere, basing their opinions on the results of private practice, will hold this affection to be rare.

Preferring to substitute official statistics rather than my own, I have arranged the following statistical table¹ from the annual reports of the Hamburg General Hospital for the years 1878-1881, inclusive. Into the female syphilitic department were admitted:

¹ Compiled by Dr. Engel Reimers, Physician in chief.

	IN THE YEAR :			
	1878	1879	1880	1881
Total number of women.	1,357	1,382	1,459	1,358
Of these affected with :				
Blennorrhœa urethræ.	222	301	292	340
Blennorrhœa vaginae.	123	200	268	327
Blennorrhœa uteri.	33	34	76	122
Blennorrhœa gland. Barth.	37	75	89	86
Eczema vulvæ.	15	44	72	56
Herpes lab. pudend.	36	89	86	75
Herpes perinaei et ani.	28	37	35	35
Herpes vaginae.	2
Herpes progenitalis.	64	126	121	112

To a number of conclusions which may be inferred from this table I shall recur later; for the present it is clear that the cases of herpes during these four years amounted to 4.71 per cent, 9.12 per cent, 8.32 per cent, 8.25 per cent, of all cases of disease admitted to the female syphilitic section of the hospital, *i. e.*, a constant average ratio larger than what is so important respecting gonorrhœal propagation, blennorrhœa of the cervix (resp. corpus) uteri and the gland. Bartholinii.

Von Bärensprung had already said (*die Gürtel-Krankheit, Charité-Annalen*, B. 9, Heft 2, p. 65, 1881), who, as is known, looked upon herpes progenitalis and herpes labialis as being rudimentary forms of zoster eruptions: "Exactly the same affection is observed, *perhaps still more frequently, in women* (herpes vulvæ); its usual seat here are the labia majora, on the cutaneous and mucous surfaces of which it occurs with the same modifications as on the layers of the prepuce in man. At times some groups of vesicles are situated also at the side, in the plica femoris. But a fact to which hitherto no attention has been called¹ is, that an obviously quite analogous exanthem formation occurs not very rarely within the vagina, and especially on the vaginal portion. It is dependent on blennorrhœa, and in its course are also formed circular erosions with vivid red borders which may easily be mistaken for soft chancre. But they are sufficiently differentiated from the latter by their superficial, undestructive character, their smooth bottom, and their non-inoculability. Moreover, after a few days they heal up as completely as the herpetic vesicular eruptions often simultaneously present on the external genitals."

Von Bärensprung bases these remarks on observations derived from an experience similar to that which fell to my lot at the Hamburg General

¹ Von Bärensprung had evidently overlooked that Duparque had already studied herpes portionis vaginalis in 1837.

Hospital; and I am sure the statistics of similar institutions in America will be similar to those given above.

Under these circumstances it were remarkable if herpes mulierum had been closely studied and described only in Germany. In France, where prostitution was early under medical surveillance, and where excellent syphilographers abound as nowhere else, herpes progenitalis early attracted attention, and was described. The literature of herpes vulvæ is not so scanty as one might easily be led to believe from Greenough's assertion.

The following passages I take from the latest thesis on this affection, by Bruneau (*Etude sur les éruptions herpétiques qui se font aux organes génitaux chez la femme*, Paris, 1880), which had already been observed by Astruc in the first half of the last century, who described herpes occurring in the female (*De morbis veneris*, T. i., l. c. iv., pp. 361-4).

"Solent . . . hydatides emerge sul bullæ aquosæ, et crystallinæ quæ numero magnitudine prominentia variæ, modo summum glandis apicem, modo coronam, modo dorsum, modo latera occiput . . . solent autem isticis modi hydatides in *femines* efflorescere; potissimum in vulvæ labiis nymphisve, sive pterigonatis clitoridi clitoridisque preputio, et carunculis myrtiformis."

Alibert (*Monographies des Dermatoses*, 2d ed., 1835, T. i., p. 147) calls herpes progenitalis, ophiolyetides progéniale, and says:

"It locates itself not only on the prepuce, but also at the introitus vaginæ; if we have fewer opportunities of observing it there, it is on account of the natural modesty of the sex, for preputial and prevaginal ophiolyetide are of an absolutely equal element."

Thus we find in France the comparative status of herpes progenitalis in men and women recognized a hundred years before herpes in general had received serious attention. In France, herpes vulvæ early became the subject of a series of monographs.

Legendre published an essay on herpes progenitalis, with three cases, based on his experience as physician to the Lourcine (*Mémoire sur l'herpès de la vulva*, *Arch. Gén. de Méd.*, 1853, vol. ii., p. 171).

More recently Fournier, through his pupils: Dreyfous (*Contribution à l'étude de l'herpes vulvaire*, *Gaz. hebdom.*, 1876), and Labouré (*Thèse de Paris*, 1879), and two lectures of his own (*Gaz. des hôpitaux*, 1878, pp. 890-950), stimulated the clinical study of this subject, and added much towards making opinion concerning it clearer.

Already in 1837, Duparque (*Traité théorétique sur les ulcérations organiques simples et cancéreuses de la matrice*) parenthetically described herpes of the portio vaginalis. Gueneau de Mussy (*Clinique de l'Hôtel Dieu*) studied this subject more closely, and Rollet (*Annales de Dermatologie et Syphiligraphie*, 1869) figured a "blennorrhagic ulceration" of

the collum uteri, also attributed to true herpes by Bruneau. After Mauriac had more accurately described herpes as it occurs in man, which he called herpes neuralgique, in a series of lectures (*Gaz. des hôpitaux*, 1876), and Tullier (*Traité pratique des Maladies vénériennes*, 1879) soon after differentiating herpes progenitalis into two kinds, the ordinary and the neuropathic, Bruneau, a pupil of Brouardel, Professor of Medical Jurisprudence, published (Thesis, Paris, 1880) an extended series of herpes cases occurring in women which, because of the great constitutional disturbance, the neuralgic symptoms, and extensive distribution of the herpetic eruption fail to correspond with the usual description of ordinary herpes, and must, in my opinion, be looked upon as zoster genitalis. Bruneau calls this "large" form "confluent genital herpes," in contradistinction to "discrete genital herpes," the ordinary form, which alone had been described by his predecessors (Legendre, Fournier, etc.).

Considering the unanimity of experience at the Hamburg Hospital, the Berlin Charité, and the Parisian Lourcine, there can be no doubt that *in women of a particular class herpes progenitalis is a very frequent malady*. Respecting the *absolute* frequency with which the trouble occurs among this class of women, the above statistical table cannot be turned to account without comment, any more than corresponding statistics of herpes occurring in the male syphilitic department can.

Into the male department for syphilis were admitted:

	IN THE YEAR :			
	1878	1879	1880	1881
Total number of men.....	634	653	768	795
Suffering from gonorrhœa.....	271	259	309	257
Herpes progenitalis.....	4	9	4	..

The number of cases of herpes treated at the Hamburg Hospital syphilitic male department is quite small as compared with the number in the female syphilitic department, almost as small as met with at the Boston Dispensary (see Greenough), and naturally enough this is only proof of what might be expected, namely, that men of the poorer classes affected with herpes only exceptionally apply at the hospital for relief. Moreover, I am convinced that in men of better condition herpes is commoner, and for reasons which shall be dwelt upon when I shall speak of the etiology of this affection. The majority of herpes in the male will be met with in private practice, and, without being much mistaken, one

will, as Greenough has done, base one's calculations of its absolute frequency in males hereon.

The conditions affecting women are altogether different. The number of herpes cases admitted into a hospital depends altogether on the instruction controlling the city medical inspectors' examinations. If they are requested to send all puellæ with a genital affection to a special hospital, then the semi-weekly examinations will secure nearly, and one might say all, cases of herpes developing, because the shortest course of this affection is not less than three or four days, and, moreover, because the trouble is not easily overlooked.

Under these circumstances, when the number of herpes cases treated at the hospital is compared with that seen by the city inspectors, quite correct statistics of herpes vulvæ in puellæ can be established. But when, as is usually the case everywhere, it is left to the inspecting physician's judgment to incarcerate or not, depending on the severity of the disease and its communicability, or the patient's benefit, it is evident many cases will be lost to the hospital, and its statistics in so much wanting. Herpes is recognized as being one of the most benign of affections both to the patient and her public. Only when herpes has developed into an erosion can it become dangerous to all concerned, in that it then, like every other wound on the body, will make syphilitic inoculation easy, and can, as such, even before the eye can see the change, favor the propagation of venereal sores. In this respect, then, as a prophylactic measure, it would be safe to incarcerate all those affected with herpetic erosions, especially uncleanly individuals, whether or not these erosions afterwards assume a normal course. Practically, only herpetic erosions will be reported by the medical inspectors, because they need be diagnosed from ordinary venereal ulcers. And even of these a number will remain undiscovered, especially when they affect, as I shall afterwards show, puellæ who are thus troubled with every menstruation. Incarceration would keep these individuals in the hospital half the year, which, considering the benignity of herpes progenitalis, would be exercising an unjust restraint. According to my experience, it is thus no exaggeration to say that the number of cases of herpes, in Hamburg at least, is *double the hospital number*, and probably even greater. After what has been said, we may conclude that the number of cases of herpes occurring in this class of the female population (puellæ publicæ) averages about two hundred cases a year, which, in proportion to the number of prostitutes under strict surveillance (usually about eight hundred) amounts to about twenty-five cent, in reality no great, but perhaps for my American colleagues an astonishing number, and which considerably exceeds the percentage (seventeen per cent) of men affected, as noted by Greenough.

Thus far we have attained only an approximate view of the frequency

with which herpes progenitalis occurs in a peculiarly susceptible special class of women. This result does not apply to women in general, but, on the contrary, herpes progenitalis is in fact a rare affection. Otherwise it were incomprehensible that gynæcologists in extensive practice meet with it rarely or not at all, and that text-books on gynæcology say nothing about this affection; and my experience of late years during which I have seen a considerable number of venereal genital maladies in married women coincides with theirs, I not having met with a single instance. It is now evident that the conclusions arrived at by members of the American Dermatological Society are correct, in so far as the *general rarity* of herpes vulvæ is concerned; but, on the contrary, the conclusion that *women as such are therefore less susceptible of being thus affected* is erroneous. Indeed, herpes progenitalis is found more frequently in women *who are only distinguished by their vocation* than in men. We may therefore say only this much: *that women are just as susceptible to herpes as men are; there is no immunity from herpes for the female sex.* On the contrary, the exciting cause which induces virile herpes is usually absent in women; but when this is present (as in puellæ publicæ) herpes is frequently found; for woman *herpes is so to say a vocation-disease.*

The conditions to which women are subject are so extremely favorable to gaining a clearer view of the etiology of herpes generally that I cannot omit directing special attention to this point. Fournier has written on the etiology of herpes in a manner that leaves little to be desired. For good clinical reasons, he speaks of the etiology of herpes labialis and progenitalis, and of herpes preputii and vulvæ together; whilst other authors, notably Legendre and Bruneau, attempt a special etiological characterization of herpes vulvæ. However, considering the close general relationship of these herpes, their description by Fournier surpasses that of other authors, even Greenough's. Etiologically, Fournier distinguishes two groups: 1st, accidental, and 2d, constitutional herpes. The first group is still further divided into three groups: 1st, herpes following injuries and surgical operations. Attempted rape has caused the development of herpes vulvæ, and often has occasioned a legal differential diagnosis on this account (see Legendre). 2, Herpes *blennorrhagique*, forming the chief contingent of male and female herpes progenitalis. 3d, Herpes accompanying chancre, an extremely rare form; but I have seen it in both sexes.

In the conclusion, Fournier gives a general summary of his views:

"It is in fact merely the *general disposition* which governs everything, all other causes are but accessory; it is absolutely superfluous to try to master herpes by making the *supposed* causes disappear."

I cannot banish the notion that the so-called constitutional relapsing

herpetes, especially herpes progenitalis, may be explained as Gerhardt has explained herpes febrilis, by the existence of *recurring local disturbances*. Considering the immense difference of its occurrence in prostitutes and married women, as has been shown, it necessarily follows that the *great chief cause of herpes progenitalis* is to be looked for in the *excessive genital irritation* to which prostitutes are exposed; all other causes are only secondary. Fournier (p. 892) admits the importance of this factor without reserve: "It is coition alone, independent of any liquids (catamenia, leucorrhœa, etc.), which provokes the eruption;" but only in so far as earlier observers (Legendre) looked upon want of cleanliness and decomposing secretions as direct causes of herpes. After all, coition is for him only a primary exciting cause, individual predisposition being the root of the affection. I, on the contrary, believe that this obscure and negative etiological prodigy can be dispensed with, and something more positive supplied to take its place. Furthermore, the objection that venereal diseases, to which prostitutes are specially liable, are causes of herpes, may be denied. This idea is put prominently forward by Greenough who says that all men affected with herpes had had some venereal disease, although recovered from years before, and he seeks corroboration for this view in similar observations made by Doyon. Contrary to this, I must affirm that, according to my experience, first, in married women affected with blennorrhœa, chancre, or syphilis, herpes is rarely seen; secondly, herpes is as often met with in prostitutes not troubled with venereal disease as in those who are. I recollect a case of habitual menstrual herpes where venereal disease was never present at the same time. However, to assert that a blennorrhœa contracted and recovered from in youth, will give rise to herpes, or, as Greenough prudently avers, at least give rise to the herpetie disposition, in a married man, years afterwards, is a hyperspeculative assumption not worth serious mention, since more palpable causes are not wanting; and Greenough himself, in another place, says: "The influence of the venereal act as the immediate cause of herpes progenitalis has been mentioned, but I do not think it has been given the importance that it deserves."

The only affection which is really so common a complication as to make an etiological dependence in this respect undeniable, is gonorrhœa and its complications, that is, those venereal affections, coition aside, which necessarily give rise to intense congestion of the parts. This local congestion and the great vasomotor irritation of the genitals seem to me to form the true connecting link between gonorrhœa and herpes gonorrhœicus, as in the case of herpes post coitum.

In prostitutes, genital irritation and acute or chronic blennorrhœa often exist together as factors in the development of "herpetic genital fluxion." This general view, obtained from observation of herpes oc-

curring in prostitutes, borne in mind, other etiological peculiarities relating to herpes progenitalis become clear. As there are men who habitually are attacked by herpes after every act of coition, so, too, there are prostitutes who have an eruption of herpes every time they menstruate. I have had abundant opportunity of observing such individuals. These people were well-acquainted with the nature of their malady, even better than many a physician may be. They dreaded every new medical inspector, because he generally attempted their incarceration until the nature of the trouble convinced him of his error by its relapses. In some, this trouble was disposed to drag on for years, whilst in others it recurred only with several menstruations to return no more. I am pleased to note that this habitual menstrual herpes had also received attention from French writers generally. Legendre says (p. 181) :

“It thus happens that some women are attacked, one or two days prior to every menstruation, by an eruption of herpes. . . .”

Fournier also mentions menstrual herpes; and Bruneau says (p. 42) :

“The herpetic eruption frequently coincides with every menstrual epoch, whence the name, *bouton de règle*, which has been given to it.”

Less frequently pregnancy and the puerperal state also induce the disposition to herpes progenitalis, which is readily explained from our point of view. Respecting the trouble in these conditions, I depend on the experience of a colleague who has observed herpes in the puerperal state: and Bruneau mentions two essays relating to this part of the subject which, unfortunately, I could not consult: A. Martin, *Herpes u. Erythem mit Scarlatina bei Wöchnerinnen. Zeitschr. f. Geburts- und Frauenkrankheiten*, B. ii., p. 225, 1875; and Ingmann, *Herpes der Schwangerschaft, Petersburger Med. Wochenschrift*, 1876. Bruneau must also be given credit for having shown that in women suffering with chr. metritis, cervicitis, ovaritis, and parametritis, every herpetic eruption is invariably preceded by increased sensibility and signs of heightened congestion of the pelvic organs. He furthermore noticed that cervical leucorrhœa, so common in those afflicted with herpes, was aggravated during the eruption. Facts like these prove that every herpetic eruption depends on a heightened congestion of the pelvic organs.

We may now satisfactorily attend to the other so-called causes of herpes, such as uncleanness, decomposing secretions, hot weather, obesity (Legendre, Bruneau), rape, impeded penile erection, due to an over-long prepuce (Greenough), all of which induce an eruption of herpes for reasons the same as those common to excessive venery, menstruation, and pregnancy, namely, *excessive congestion of the genital organs*. And this is universally found to be the true cause and basis of herpes progenitalis.

Perhaps the reader will excuse me for trespassing yet awhile on his

patience in order that the material offered by herpes in woman may be still further utilized in elucidating several other points connected with herpes progenitalis.

The diagnosis of herpes vulvæ is not difficult, but none the less important with reference to the statistics given above. While the vesicles are still intact, the diagnosis is readily made even by the unpractised at a distance. They cannot be mistaken for anything else, being yellowish, translucent, and arranged in clusters. When the epidermis has given way, and superficial, partially crusted-over erosions present, the surface must often first be carefully cleansed before we can see whether the trouble is a superficial wound, a burn, an eczema, a chancre, or herpes. Herpetic erosions are well defined, as though punched, superficial and flat, and of a bright reddish hue; they are discrete, coalescent, or confluent. In any case, as Fournier first remarked, the clean, sharply defined contour, and crescentic (polycyclical) arrangement make herpes easy to diagnose.¹

It will, therefore, not be assumed that the above statistics are at fault because of mistaken diagnoses. To prove that attention was paid to eczema (intertrigo) it received mention in the first statistical table given above. It is also evident that twice as many prostitutes were sent to the hospital with herpes than with eczema of the genitals. Moreover I hold, contrary to text-books, that herpes progenitalis in man cannot be confounded with balanitic erosions.

I know only two affections which, because of their form and rarity, may be mistaken for herpes progenitalis, but then only during the first few days of their existence. Chancres in the male now and then occur in the inner surface of the prepuce, are benign in appearance and very slowly involve the surrounding tissues, and these at first sight look like herpetic erosions. They are the chancres of Tyson's glands which develop as inconsiderable epithelial proliferations in small inconstant contiguous groups of sebaceous glands. Usually a group of from four to six neighboring glands are attacked. The round follicular openings are eroded, abnormally patulous, and acutely hyperæmic, so as to give the impression of a herpetic erosion. If a simple dusting powder is prescribed for this affection, it drags on, and the typical herpetic course being wanting, slight periglandular induration becomes manifest, succeeded by glandular disintegration and confluent, rapidly spreading ulceration, all of which impress the physician that he is dealing with a soft chancre, the course of which was protracted by its unusual seat. These exceptional cases, from the favorable prognosis they may elicit, are apt to discredit

¹ Observation xiii. of Bruneau, despite the absence of the polycyclical contour, was diagnosed as a probable herpes. It seems to me to have been a case of chancre or traumatism.

the physician's ability. These glandular ulcers are rarely so close together as a group of herpetic vesicles, and touch, aided by a magnifying lens, will make a mistake in diagnosis impossible. It is quite possible for these glands to become affected with a venereal pseudo-herpes on the labia minora of women, but I cannot recall such a case. Broad condylomata occurring on the anterior edge of the labia minora now and then are mistaken for herpes labialis min. This is due to the tendency of the labia to œdema, and especially apt are the thin edges to assume circumscribed localized, indurated œdemas when these lips are the seat of inflammatory affections. The free borders of the nymphæ minora are less frequently the seat of soft chaneres than of recurring herpes, especially menstrual herpes; but on the other hand, they are the favorite seat of frequently recurring papular and papulo-eroding secondary syphilides. The accompanying œdema makes a mistake in diagnosis easy by giving these different affections a similarity of appearance. During the acute stage of both affections, the œdema presents knob-shaped intumescences; when the œdema has diminished, the tissues feel harder than normal, presenting erosions on a shrunken and wrinkled surface. Thus, herpes is associated with much œdema and subsequently induration; condylomata have an acute onset followed by disseminated erosions—these data may mislead, but after the lapse of several days the error is corrected. This secondary syphilide, coming on simultaneously with menstruation, is especially liable to be mistaken for menstrual herpes. The diagnosis is always corrected by the subsequent course. I have seen mild acute syphilides oftener mistaken for herpes than vice versa. I recollect cases of this kind in which, after some days of observation in the hospital, the mistaken diagnosis was corrected, then being treated with mercurials, recovery speedily followed. On the labia majora error of this kind is hardly possible. I admit there may be another mode of interpreting these pseudo-herpetic condylomata, namely, that genuine herpes, *e. g.*, menstrual herpes, like traumatic inflammation, leads to the deposition of syphilitic matter. I commend this question to the attention of medical inspectors, but shall not here attempt its solution. Herpes I have never seen an initial syphilitic symptom. It is known that F. v. Hebra was one of the first who, for good reasons, clinically differentiated herpes labialis and progenitalis from zoster, whilst von Bärensprung still conceived them as being rudimentary forms of zoster. The reasons which have since always been advanced in favor of this differentiation apply well enough to man. Even respecting this question, the study of herpes vulvæ will guard against extreme views. Two facts in the herpes of females evidently prove that the transition from herpes progenitalis to zoster genitalis does occur, namely the occurrence of "*confluent herpes*" (Fournier, Bruneau), which thus far has been described as occurring

only in women, and again, *the greater areal distribution of herpes vulvæ*. A great variability characterizes the "confluent herpes" described by Bruneau, but the extensive distribution exceeding that of simple herpes is common to all forms of it; besides, before and during the eruption there are more or less constitutional disturbance, much nervous distress (rectal and vesical tenesmus, ovarian hyperæsthesia, hyperæsthesia, and eventually anæsthesia in the affected cutis, neuralgias, etc.), and, finally, almost without exception, the genital organs are congested and even inflamed. I am sure these herpes are in part analogous to that form described by Mauriac as *herpès neuralgique*, and in part to true zoster, and not being altogether distinguishable from herpes vulvæ, they are the connecting-link between herpes progenitalis and zoster genitalis. I, like Greenough, hold Mauriac's neuralgic herpes to be a true zoster.

Let us now consider the areal distribution of herpes vulvæ. In men, herpes rarely affects the penile cutis, and is scarcely ever found on the scrotum and thighs, but, as is known, is usually limited to the glans penis. In man, the eruption almost invariably corresponds with the course of the ramus dorsalis penis, a branch of the pudic nerve, and indeed generally a peripheral branch, more rarely a branch given off in the course of the nerve. The parts affected in the order of frequency, as given by Greenough, will be generally accepted, are the sulcus præputialis, the lamina interior præputialis, the glans, margo præputialis, and cutis penis. In women this is about as follows: labia minora, præputium clitoridis, labia majora, clitoris, introitus vaginæ et carunculæ myrtiformes, perineum, regio analis, plica genito-cruralis, mons Veneris, mucosa analis, portio vaginalis, vagina (portio media). Here it is evident that besides the ramus dorsalis clitoridis a series of other nerves need be taken into account:

- | | | |
|---------------|---|----------------------------------|
| XII. Dorsalis | } | nerv. ileo-hypogastricus. |
| I. Lumbalis | | ram. abdominalis; ram. labialis. |
| II. Lumbalis | } | nerv. genito-cruralis. |
| II. Lumbalis | | nerv. genito-cruralis. |
| II. Sacralis | } | nervus pudendus. |
| III. Sacralis | | ram. pud. sup. dorsal. clit. |
| IV. Sacralis | | ram. pud. inf. perinei. |
| | | ram. hemorrhoidalis inf. |

Much importance has been attached to the fact that in man, contrary to unilateral zoster, this herpetic eruption is symmetrical, and at least crosses the median line. But if we take into account that both ram. dors. penis through which originate the herpetic eruptions almost extend to the median line of the body, and that both communicate with the sympathetic on the penis, we shall not be surprised. In woman, the union of the body being incomplete in the genital sphere, the case is different. But even then the occurrence of herpes is symmetrical, though in the

great majority of cases it is unilateral, the eruption crossing the median line when organs, such as the præputium clitoridis, the perinæum, the portio vaginalis, etc., are attacked, which are unsymmetrical. In the plica genito-cruralis, and in the mons Veneris, I have only seen a unilateral herpetic eruption representing a rudimentary zoster, so that also in this respect female herpes is a connecting link between typical herpes and zoster.

It may not on this account be without interest to briefly elucidate several other points of the supposed difference existing between herpes and zoster.

Greenough as well as *Hebra* (B. I., p. 309) asserts that pain never accompanies herpes progenitalis as is the case with zoster. According to my experience, this is incorrect, both in men and women. Not always, but often pain not only accompanies the development of the exanthem, but usually precedes the eruption by one or two days. I have very frequently observed "herpes simplex vulvæ" with pain; in "confluent herpes" (Brunneau), moderate pain is not only common, but neuralgic pains are the rule.

Finally, the circumscribed character of herpes progenitalis and labialis corresponding to the areal distribution of a nerve terminal has been looked upon by some authors as peculiar, because zoster is usually distributed over the entire course of a nerve. This, however, is due to the fallacious view entertained that zoster graphically maps out the cuticular distribution of a nerve, in an exaggerated degree. Even in those cases where the areal distribution is very great, and numerous successive eruptions roughly mark the nerve course, a complete series of cuticular areas are left unaffected, though notoriously supplied by the same cuticular nerves. The sensitive cuticular areas are not sharply defined, but merge into each other by indistinguishable gradations, and the terminal nervous distribution is similar, and never, not even the smallest cuticular nervous area is totally affected, after the manner of an eczema.

Despite the attachment of zoster to the course of special spinal nerves in general, I have been more impressed by the apparent constant *relative limitation* of the exanthem. It would be worth while investigating whether disturbances of sensibility are common to the nervous distribution, or limited like the exanthem. *The limitation of zoster to certain points of the terminal distribution of nerves is its characteristic mark*, and from this point of view I would call herpes progenitalis a rudimentary form of zoster, in the sense of von Bärensprung.

Naturally, conditions must be present, which is the case with the trifacial and pelvic nerves, that favor the bilateral development and relapsing of herpes; and it seems quite plausible to assume, with von Bärensprung, that the subordinate peripheral ganglia, of which these nerves

have many, represent the foci of *those* herpetic eruptions. In this respect, it would seem important to ascertain with greater statistical exactitude, in the future, the period of incubation of herpes progenitalis.

In men, the interval of time elapsing between the occurrence of the cause (coition) of herpes and the eruption being quite determinable, a legitimate conclusion may be formed as to the greater or less physiological separation¹ of involved ganglia.

Judging by the clinical material at my command, the eruption oftenest occurs on the second or third day, and not on the first day after coition. Clinically, nothing speaks so strongly for ganglionic implication in zoster and herpes progenitalis as the subsequent eruption of the exanthem, and period of incubation, the exciting cause of necessity overcoming many obstacles to effect the result. In men, herpes progenitalis is usually found over the course of the ramus dorsalis penis, which forms connections with the sympathetic, and the large dorsal vein being, according to Henle, almost the only afferent circulatory conduit during penile erection (the venæ prof. penis being compressed by the perinei prof. inf. muscles), may explain the pathogenesis of herpes progenitalis, in a manner similar to that made probable for herpes labialis febrilis by Gerhardt, namely, compression of the nerves.

THE TREATMENT OF ECZEMA.

BY

DR. MCCALL ANDERSON.

(Continued from page 306.)

AS already stated, the application of water dressings covered with oil-silk is favorable to the development of eczema, but this remark does not apply to all kinds of impermeable dressings; indeed, in many cases the use of pure vulcanized india-rubber and vulcanized india-rubber cloth is often of great value in more ways than one. This method of treatment was introduced by Colson, of Beauvais, in the year 1868, in the following year it was adopted by Hardy and Hebra, and I have for a good many years employed it on a very extensive scale, and with excellent results. It acts in a variety of ways: it excludes the air, keeps the parts warm and at a uniform temperature, and promotes the secretions from the follicles of the skin, which it retains, so that they macerate and favor the removal of the epidermis. According to Hebra,

¹ By physiological separation (*physiologische Entfernung*) I understand more or less numerous interspersions of ganglionic centres in the course of a nerve.

too, it does good in virtue of the sulphur which it contains. It is often one of the best means of removing morbid products, as in the case of eczema impetiginodes of the head, but it does more than this, for in many cases it, unaided, entirely removes the disease. Yet it must be admitted that it is occasionally useless or even injurious, although we are unable to say beforehand with any certainty in what case it will prove successful or otherwise. The india-rubber coverings should be made so as to fit the affected parts pretty closely but comfortably, and when the patient is unable to use them by day they may still prove of service when employed at night, although not so surely and rapidly; but if the legs are affected their application by day, when the patient is going about, is indispensable. If the hands or feet are affected, the india-rubber should take the shape of gloves or stockings; if the head, a nightcap may be made of it; if the whole body is involved, a complete suit of india-rubber underclothing may be worn. For the arms and legs Martin's vulcanized india-rubber bandages are preferable, of which I shall have more to say when referring to the treatment of eczema of the legs. These dressings should be removed night and morning in order that they as well as the affected surfaces may be thoroughly cleansed and dried, for the usual effect of their application is to make the parts very moist, owing to the retention of the secretions. If the skin is frayed or irritated in any way by their constant use, they may be suspended for a day or two, or the irritated part may be covered with a piece of clean linen spread with one of the soothing ointments already mentioned. Although the india-rubber is apt to be deteriorated by the simultaneous application of other remedies, especially ointments, it is one of the advantages of this method of treatment that, when necessary, it may be combined with any of the other local measures already indicated. The following cases illustrate the value of impermeable dressings:

"Allan McA., aged forty, latter, was admitted to the Glasgow Skin Dispensary on December 23d, 1868. The disease, eczema manuum, had appeared for the first time about three years before this date, and somewhat in the following manner. He first noticed a number of small 'blisters,' about the size of pin-heads; these, after remaining a short time, burst, discharging their contents, and leaving a raw surface, which was extremely itchy and 'leeted' very much. The eruption appeared first on the dorsal surface of the right hand, then on the sides of the fingers, and lastly on the dorsal surface of the fingers. Shortly after this, a similar eruption appeared on the left hand. The disease lasted a considerable time, and disappeared under medical treatment. The second attack commenced about eight weeks previous to admission, appearing in the same manner and order as before; but this time the palmar surfaces of the fingers were implicated as well as the above-mentioned parts.

"The appearances on admission were:—On the left hand the eruption implicated its dorsal surface, as well as the dorsal surfaces and sides of the fingers; these parts were considerably infiltrated, covered with a

serous exudation, and were the seat of numerous excoriations. The right hand presented similar appearances, but the infiltration of the skin on its dorsal surface was much more marked. The eruption was extremely itchy, and was rapidly extending. The patient's general health was good. He was ordered to procure a pair of india-rubber gloves, and to wear them constantly for a fortnight.

"On January 6th, 1869, the disease had in most parts completely disappeared, a faint reddish blush only being left on the sites of the previous eruption. He was ordered to continue the use of the gloves for another fortnight and then to return—which, however, he failed to do." (Reported by Mr. J. D. Walker.)

"Louisa W., aged four years and eight months, admitted to the Glasgow Skin Dispensary June 28th, 1869. Her father stated that the eruption, *eczema capitis*, first made its appearance when she was three months old, and disappeared three months thereafter. She remained well till after an attack of scarlatina at the age of a year and a half, when it reappeared, since which time she had never been altogether free of it.

"The appearances on admission were as follows:—The eruption implicated the external ears and the whole of the scalp; these parts were very red, much infiltrated, exuded an abundance of clear serum, and were studded with crusts. The patient complained of great irritation of the skin and of burning heat. She looked rather delicate, but her digestive organs were in good order, although the year before she had been troubled with worms. Various remedies had been tried, but to little purpose. She was ordered a vulcanized india-rubber cap, which was to be worn constantly.

"On July 15, the infiltration of the skin and the exudation had completely disappeared, the itching and burning heat were almost gone, and a faint red blush was all that remained of the previous eruption. The india-rubber cap was continued. The patient did not return." (Reported by Mr. Robert Sinclair.)

Quite recently Mr. Beiersdorf, of Hamburg, has prepared, at the suggestion of Dr. Unna, a number of plasters, some of which are most useful in the treatment of *eczema*, but as these are specially, though not exclusively, applicable to cases affecting the hands and feet, it will be better to defer their consideration until the treatment of these parts is referred to.

When the *eczematous* eruption occupies a limited extent of surface, and especially when the patches assume the form of *eczema sclerosum* or *verrucosum*, and when it resists other treatment, it may require to be attacked with strong local applications, while it is not, as a rule, so much under the influence of internal medicines as when it covers a large area. In such cases, strong solutions of potassa fusa or chloride of zinc, or even these caustics in the solid form, may be employed locally in the manner and with the precautions previously described, and often with benefit, but they must be omitted whenever the infiltration of the skin is removed.

Canterization with solid nitrate of silver may sometimes be resorted to

instead of the above, or a mixture of equal parts of carbolic acid and spirit may be painted over the part once a week; or the tincture of iodine night and morning, a poultice of bread and hot oil being applied about once a week to hasten the removal of the red skin which forms a covering to the eruption, and prevents the new layers of iodine from coming in contact with the disease itself. In these cases the treatment recommended by Auspitz¹ may sometimes be adopted with advantage. This consists in rubbing the affected parts with a piece of moist flannel dipped in fine sand, or with sandstone or pumice-stone, until the part is reddened and excoriated, after which *pix liquida*, *oleum cadini*, or *oleum rusci*, is well rubbed in, after which they are covered with vulcanized india-rubber cloth; this is repeated once or twice a day, but omitted for a day occasionally, during which time the surfaces may be covered with pieces of linen spread with some soothing ointment, such as *diachylon ointment*. This treatment, which must be carried out with caution, he considers specially applicable for cases affecting the ears, brow, nape, and extremities, but it should not be applied to parts such as the genital organs and face, which are provided with much loose cellular tissue.

In the same class of cases an ointment of chrysophanic acid, varying in strength from gr. x. up to ʒ ij. to the ʒ i. may be tried.² The ointment should not be used very strong at first, as some skins are very easily over-irritated by it. The patient should be warned that it stains everything with which it comes in contact, not excluding the hair and nails, and he should be told that if the surrounding skin assumes a purplish red color, or becomes the seat of swelling or burning heat, it should be suspended for a time. If no inflammation results, the ointment may be rubbed in very firmly, but at the outset with caution. If under this treatment the patches of eczema disappear, their previous seat will probably be indicated by white surfaces surrounded by skin which has been reddened by the use of the ointment, for the healthy is more likely than the morbid skin to be inflamed by it. Or instead of chrysophanic acid, a ten-per-cent ointment of pyrogallie acid³ may be employed, and with the same precautions. It does not stain the skin, etc., nearly to the same extent as chrysophanic acid, but on the whole it is not so service-

¹ "Ueber die mechanische Behandlung von Hautkrankheiten," von Professor Heinrich Auspitz. Wien, 1877. Wilhelm Braumüller.

² R. *Acidi chrysophanici*..... gr. x.
Glycerini (Price)..... ʒ i.
Ung. simplicis..... ʒ viij.

M. Sig. Apply night and morning.

³ R. *Acidi pyrogallici*,
Glycerini (Price)..... āā ʒ j.
Cerati Galeni..... ʒ j.

M.

able as a rule; and under no circumstances should it be applied over an extensive surface, else, as the result of its absorption, it may give rise to constitutional symptoms such as fever, digestive derangement, strangury with greenish-black urine, etc., and may even prove fatal. It must be distinctly understood that the two remedies just mentioned are only to be employed in the class of cases indicated: and while they are often of use, they are not nearly so certainly effectual in the treatment of eczema as they are in psoriasis.

Of all the local means for the removal of limited eczematous eruptions, none are superior to blistering. This may be done by means of a solution of bichloride of mercury (3 i. to the 5 i. of alcohol), the fluid being painted over the eruption, and allowed to dry upon it. There is a certain risk, however, of the absorption of the mercury to such an extent as to produce salivation, so that it should not be used except when the patch of eruption is small, and even then the danger is by no means obviated, as I have witnessed the supervention of salivation under these circumstances.

The best and safest blistering agent is cantharides in some form or another. That which I used to employ almost exclusively is the glacial acetum cantharidis—that is, acetum cantharidis prepared with glacial acetic acid.¹ It should be made in small quantities at a time, and kept in a well-stoppered bottle, the stopper being removed for as short a time as possible, and when not in use covered with leather, otherwise its strength diminishes, and much annoyance is thereby occasioned. A little of this solution is taken up by means of a paint brush, and painted over the part till it becomes perfectly white. If the fluid is of full strength, and the skin thin, as on the face, it usually blisters it at once; but if the opposite holds, and especially if the head or palms of the hands are to be attacked, it may require to be painted over them more freely. After the skin is thoroughly whitened, a poultice may be applied, but the cuticle rarely “rises” so completely as after a common blister. One application is often sufficient to remove the eruption; but if necessary, it may be repeated weekly, the crust produced by the previous eruption being softened with oil and removed before each re-application.

A couple of months ago, a gentleman, aged about 35, and otherwise in perfect health, consulted us with regard to an eczematous eruption on the head of twelve years’ duration, for which he had been repeatedly shaved, and had consulted many physicians of eminence. Tar had been applied to the scalp systematically for some time, and every conceivable

¹ This solution is made at the New Apothecaries’ Company, 57 Glassford Street, and at Frazer & Greene’s, 113 Buchanan Street, and 469 Sanchiehall Street, Glasgow, Scotland.

ointment had been used, but without avail. After his hair was removed, I found that the disease corresponded with the form described under the name of *eczema squamosum*: it covered the whole head, and, as usually happens in these obstinate cases, was accurately limited to the hairy parts. The scales on the surface were numerous, the itching severe, and on the crown, front, and sides of the head, the infiltration and redness of the skin were great. These parts were blistered with glacial acetum cantharidis—the fluid requiring to be very freely applied, owing to the thickness of the skin—and the rest of the scalp, which was less severely affected, was painted with tincture of iodine morning and evening. In a fortnight the iodine was omitted, and when the crusts and scales produced by the iodine and the blistering fluid were removed, the scalp appeared perfectly healthy, and without a vestige of the previous eruption. To consolidate the cure, however, tincture of iodine was painted over the whole head night and morning for a fortnight, and when the red skin was removed the scalp looked remarkably well, there being not even the vestige of a scale, which can rarely be said even of the head of a healthy person. No other treatment was resorted to, and the gentleman has since been in America. In the interval his hair grew in greater force than ever, and he is delighted to be rid of his old and indefatigable enemy.

Many cases such as these might be mentioned, but I may just refer to one more, which many of my students had an opportunity of seeing. “A woman, pretty well advanced in years, came to the Dispensary for Skin Diseases, Glasgow, in the spring of 1863, to get advice about an eczematous eruption of old standing, which covered the whole of the palmar surface of each hand. She had likewise a tendency to eczema of the leg, which was removed by means of the ‘*tinctura saponis viridis cum piece*,’ a preparation previously referred to. It is to the hands, however, that I wish to allude. The eruption here assumed the form of *eczema rimosum*, the fissures being very numerous and deep, and the infiltration of the skin great. Itching was mingled with pain, but the latter, on account of the fissures, predominated. Owing to the pain and stiffness, the hands were kept constantly in a semi-closed position, and she was unable to use them. Each hand was blistered with the glacial acetum cantharidis, which had a marvellous effect. The eruption disappeared completely, and the patient returned with joy depicted in her countenance, and opened and closed her hands with perfect facility, not unmingled with pride.”

The blistering agent which I am in the habit of employing at the present time chiefly, and one which does not produce as much pain as the glacial acetum cantharidis, is Smith’s “*emplastrum cantharidinis liquidum*” (T. and H. Smith & Co., London). After shaking the bottle, a paint-brush is dipped in the mixture, and the affected part painted with

it immediately, as it dries up very quickly. In five or six hours thereafter, a poultice is applied for an hour or two, by which time the blister is fully formed. It is then dressed like an ordinary blister, and allowed to heal. Instead of this fluid, Brown's "cantharidine blistering tissue" (T. B. Brown, Birmingham) may be used, which should be cut into pieces of such a size as to insure its lying upon the affected part without wrinkling. After the cuticle rises, it is treated like a common blister.

(To be continued.)

Correspondence.

DERMATOLOGY AND SYPHILOGRAPHY IN GREAT BRITAIN.

(From our Special Correspondent.)

OF late, considerable activity has been shown in the above departments of medicine; a certain number of interesting communications have appeared in the medical papers, but it is chiefly to our medical societies that important and valuable communications have been made, often accompanied by the exhibition of specimens and patients.

Under the title "VACCINIA," Dr. Longstaff (*Brit. Med. Jour.*, March 10, p. 454), relates the following case: He vaccinated a strong boy of his own, three months old, with calf-lymph received from Dr. Warlomont, of Brussels, and proceeding from a case of spontaneous cow-pox successively transmitted from calf to calf. The child at the time of vaccination had some red papules on the cheek which developed into vesicular eczema by the third day; the vaccine vesicles, however, ran a normal course, and were large and well formed on the eighth day; but about a day earlier a crop of papules appeared around the points of inoculation and a few on the body; by the tenth day the primary vesicles were surrounded by at least fifty circular, discrete, well-formed 'vaccine' vesicles, and similar ones appeared on the head, ear, and neck, with a few on the body. These increased in number, and on the thirteenth day had become confluent on the arm, but the swelling and constitutional disturbance were very slight, and by the fifteenth day all the vesicles had scabbed. This eruption was considered by Dr. Warlomont to be an example of what has been called "Vaccine généralisée," but the present writer agrees with Behrend (*Die Hautkrankheiten*, ed. 2, pp. 310-311) in considering this term inadmissible unless it be proved that the contents of the secondary vesicles consist of true vaccine lymph, an important point which has not been demonstrated; he would therefore prefer to regard the present case as an example of herpeticiform vaccinal eruption.

The rare condition of gangrene, which, as pointed out by Mr. Jonathan Hutchinson, sometimes supervenes on chicken-pox and vaccination, is illustrated by Mr. Warrington Howard in "A case of GANGRENOUS VARICELLA" (*Brit. Med. Jour.*, May 12, p. 904). An infant, one year old, was admitted into hospital with numerous gangrenous patches on the skin. It was miserably ill-nourished and neg-

lected, weighing only six and a half pounds. On the left side of the scalp was a large scab which left a deep ulcer on removal, evidently formed by the confluence of several circular sores; on other parts of the scalp and on the face were numerous circular scabs, a quarter to half an inch in diameter, covering similar ulcers. On the chest, abdomen, and back were a number of black gangrenous patches of circular outline, one-half to one inch in diameter, and in some parts just becoming confluent; the larger spots were all on the abdomen, and the skin around the patches was of a dusky red color. Besides the above lesions, there were scattered over the trunk and limbs numerous small scabs like ordinary fading varicella spots, and a few small vesicles and papules. The child often vomited, had a weak rapid pulse, a temperature of 104° , and the left lung was dull on percussion at the base. The history showed that both parents were healthy and had had six children, of whom three had died from infantile diseases and two were healthy, the present child having been puny and sickly from its birth; it was vaccinated two months ago, and the vaccine vesicles had run a perfectly normal course and had healed well. A week before admission, a crop of small, red pin-head-sized spots came out on the face, chest, and abdomen, which afterwards developed into 'blisters' like mature vaccine vesicles; no other children in the house were suffering from chicken-pox. On the third day of the eruption, the case was seen by the house-physician and recognized as ordinary varicella, but on the next day the spots became black and began to increase in size. The child died on the fourth day from admission, and the necropsy showed that the gangrene on the abdomen had penetrated the entire thickness of the skin, exposing the muscles beneath; elsewhere the ulceration was less deep; there was pleuro-pneumonia and pyæmic abscesses in the lungs, but no other internal lesion, and the joints were normal.

In a "Clinical Lecture on a rapidly successful treatment of ERYSIPELAS" (*Lancet*, March 10, p. 400), Mr. Barwell gives an account of six cases of this disease, five traumatic and one idiopathic, which were all treated locally only by the free application of white lead paint (apparently ordinary house-paint), with the result of recovery in about a week, the temperature rapidly falling and being usually normal by the second or third day. He believes it acts entirely by affording a protective covering and completely excluding the air, in which case it is not easy to see why it is preferable to other similar methods which have been long employed, *e. g.*, painting with collodion.

Dr. Whiphram communicated two cases of "ERYTHEMATOUS ERUPTION IN TYPHOID FEVER" to the Clinical Society on April 13. The first case was a man aged 36, who had been ill for a fortnight with symptoms of fever, but without diarrhoea. On admission he had sore throat and headache, and there was a bright erythematous eruption on the trunk and extremities; tongue thickly coated, pulse 128, and temperature nearly 105° . Next day the eruption was more marked on the legs and arms, and had extended to the feet; he was delirious on the third day, and a gentle purgative was given, followed by diarrhoea which continued until his death next day. There were no typhoid spots, but the necropsy showed extensive ulceration of Peyer's patches. The second case was a child aged four, who had already had scarlatina; fever came on the day before admission, when the temperature was 104.2° and pulse 120; the tongue was red at the tip and edges, with prominent papillae. On the day after admission, a red eruption was noticed on the legs, and next day this had extended and was very brilliant; the tonsils were red and swollen, and there was constipation. Four days after admission, the eruption had greatly faded, and disappeared on the fifth day. Six

days later, the characteristic spots of typhoid appeared, and the child died with ordinary symptoms on the nineteenth day from admission, and on examination extensive ulceration of Peyer's patches and great swelling of the mesenteric glands were found. Dr. Whipham pointed out that although Peyer's patches had been noticed to be much swollen in scarlatina, ulceration had not been met with, and thought the question was as to whether these cases were instances of double infection with the poisons of scarlet and enteric fevers: but from the analogous occurrence of similar erythemata in variola, pyæmia, etc., he concluded that they were examples of erythema occurring in typhoid, and not mixed cases. In the discussion, Dr. Mahomed mentioned that similar red rashes had been noticed in nearly all forms of specific fever, in cholera, diphtheria, etc. The present writer called attention to the occurrence of scarlatiniform rashes from a very great variety of causes in addition to those already mentioned, *e. g.*, drugs, wounds, and operations, the puerperal state, etc., and thought the common bond of connection was irritation of the central nervous system followed by vasomotor paralysis, this being either direct, as in some traumatic rashes, or due to foreign matters circulating in the blood, as drugs, septic materials, etc. He had found the difficulty of diagnosis from scarlatina to be often very great, and gave instances of pharmacal eruptions (salicylic acid, quinine), which had been followed by profuse desquamation: caution was therefore necessary, and in any uncertainty he thought it good practice to isolate such cases. Dr. Andrew Clark thought the nervous system was instrumental in causing such erythema, and had been accustomed to consider scarlatiniform eruptions to occur in those cases of typhoid fever in which nervous symptoms were especially prominent; he said the irritation sufficient to cause erythema was often very slight, as he had often seen a diffuse bright-red injection of the chest of nervous women when exposed for auscultation. Dr. Broadbent would not confound the delicate erythema preceding typhoid with scarlatina, but had constantly seen all forms of combination between these two fevers, and thought the second probably a mixed case.

In a paper on "PHAGEDENIC CARBUNCLE" (*Brit. Med. Jour.*, March 17, p. 510), Mr. Masterman calls attention to the fact that in the grave spreading forms of carbuncle which preferentially attack the face, albumen is often present in the urine in large quantity; this should, therefore, be always looked for, as well as sugar. When the carbuncle does not spread, the urine is usually normal. In treatment he recommends perchloride of iron and avoidance of alcohol.

Two interesting cases of "ANTHRAX" were communicated to the Pathological Society on March 6. The first patient was a man, aged forty-three, who worked in a tan-yard; he was scratched one morning on the cheek by an undressed hide: itching soon came on, and by evening a "boil" had formed; in the night, he had a rigor, and was delirious. Five days later, he came under the care of Mr. Davies-Colley, who found a bright-red swelling with a depressed black centre near the corner of the mouth; the swelling rose abruptly about a sixth of an inch above the surrounding skin, and the gland behind the angles of the jaw were much enlarged; the man was very ill, weak, and feverish. The tumor was at once excised, and a fortnight later the patient seemed quite well. Abundant bacilli were found in serum oozing from the tumor, but none in the blood. The second case, under Mr. Bryant, was a workman in the same yard. Four days before admission, he noticed a small papule on his cheek, but felt quite well. In the evening, the papule had doubled in size, he felt ill, and was much worse next morning, the glands beneath the chin being enlarged and the throat swollen. When admitted, he was almost torpid, with very rapid weak pulse, and other

unfavorable symptoms; the malignant pustule, which had a sloughy centre and a surrounding ring of vesicles, was excised, and the wound touched with carbolic acid, but the man died in ten hours. Dr. Mahomed, at the necropsy, found characteristic lesions in the lungs, stomach, and intestines: bacilli were also found.

A valuable paper on "DELHI OR ORIENTAL SORE" was read to the Epidemiological Society on March 7 by Surgeon-General Murray, who was president of a commission appointed by the Indian Government to investigate the disease in 1865. The disease appeared on exposed parts of the body, at first as a small pimple, like an irritated mosquito-bite, and remained in the same condition for days, weeks, or even months; it then slowly increased, and a thin fluid oozed from the top, which dried, and formed a circular scab, gradually increasing in size and thickness. This, on removal, exposed an indolent ulcer with undermined edges and lobular granulations in the centre, like raspberries in healthy people, but paler and bluer in cachectic subjects. The ulcers, when very broad, showed signs of cicatrizing from the centre, and in all a depressed scar was left after healing. This was the natural course of the disease, which might last six months to two years or more, when uncomplicated by leprosy, syphilis, etc., which were rendered more fatal by the presence of the ulcer. It seems identical with the "Parangi," of Ceylon, "Yaws," of the West Indies, and "Bouton," of the eastern and southern shores of the Mediterranean, and is endemic at Delhi, Mooltan, and Lahore. The disease is considered to be parasitic, the foul water of wells being the habitat of the parasite. One well on being cleared out yielded a cartload of bones (!), but the water had been constantly used for drinking and washing. Nearly all the dogs in Delhi had the disease in the nose. The parasite had not been detected with certainty, but the disease was reproduced in twenty-three out of twenty-four inoculations. The treatment recommended was to avoid impure water, or to boil it, and to clean all wells once a year; locally, destruction by caustics and carbolic dressing gave the best results.

The subject of "SYMMETRICAL GANGRENE," which may be considered the most extreme form of vaso-motor disturbance, was brought before the Clinical Society by Dr. Southey on April 27, in the case of a boy, aged nine, who, on admission, was very emaciated and cachectic, semi-delirious, with a very feeble pulse of 148, and no physical signs in the thorax. The tip of the right index-finger was gangrenous. After a few days, the right thumb and right second finger became first red and throbbing, then livid, and finally gangrenous at the tips. A little later, exactly similar lesions developed on the pinna of the right ear, on the extremity of the nose, and on the tip of the right middle finger: then mottling appeared all over the trunk and limbs, and developed into raised spots and patches like urticaria tuberosa or erythema tuberculatum. The spots first itched, and then became painful and tender, but gradually subsided, leaving only some pigmentation. Finally, all the fingers and the thumb of the right hand became gangrenous and slowly separated, as did also the thumb, index, and little fingers of the left hand. The boy became very prostrate from broncho-pneumonia, but from this he slowly recovered. Two months after admission, however, he developed intermittent hæmaturia, bloody urine being passed alternately with normal non-albuminous urine. On some days, there were distinct blood-corpuscles passed, on others only hæmoglobin. The blood was accompanied by abundant oxalate crystals, but no casts. All these symptoms subsided in six months, when the boy was discharged well, but with the loss of his fingers. Dr. Andrew Clark said he was familiar with such forms of gangrene in connection with rheumatic gout. Dr. Barlow had seen two or three less severe cases. The most important

feature they presented was not the gangrene, but the vaso-motor disturbance. In one case, a man of thirty-five, who had been generally regarded as rheumatic, the attacks, which usually occurred in winter, were ushered in by pain in the lower extremities, followed by the appearance of bluish-red patches on the skin. When seen just after an attack, there was a distinct patch over one trochanter, while one toe was gangrenous, and all of them blue. In two other cases, in female children about three or four years old, the attacks occurred between September and April, being rare in the summer, when they were associated with rapid changes in temperature. In one child, the lower limb affected was intensely painful and black from above the ankle to the toes, and presented an alarming appearance. It remained so about three hours, and then the attack passed off, the child seeming quite well again. She had several attacks of the kind in the legs and forearms. In the other case also, attacks occurred on cold days, and on several occasions were accompanied with violent stomach-ache, two or three hours after which dark-colored urine containing hæmoglobin, oxalates, and albumen would be passed, but only once after each attack. He considered the disease to present many points in common with paroxysmal hæmaturia. It was a disease of winter, but the resemblance to ague was not marked, as there was no sweating stage, but only a cold one. The child who had typical paroxysmal hæmaturia had blue finger-ends at the times of attacks. He thought that the application of cold was a more rational treatment than the employment of warmth, as in frost-bite. He had seen a case of paroxysmal hæmaturia in a child in which cold bathing gave good results. Raynaud's treatment by the application of the constant current to the back was also good, the object being to diminish the irritability of the vaso-motor centres. There was no association in his cases with rheumatic gout, but such a connection had been described by Hutchinson. Mr. Cripps regarded the affection as an essentially local complaint, and gangrene as its principal feature. The cases were analogous to frost-bite, for the production of which no special bodily condition was necessary, but only exposure. Children who were attacked by symmetrical gangrene would no doubt have also suffered from chilblains, owing to weak circulation. He instanced the case of a young woman who developed symmetrical gangrene after child-birth, and thus lost both lower extremities. He did not think it right to apply cold to gangrened limbs, but recommended them to be wrapped in cotton-wool, and opium freely given in small doses. Dr. Barlow explained that he didn't recommend cold in gangrene, but in local asphyxia. Dr. Mahomed had seen two cases similar to Dr. Southey's, in one of which there was intermittent hæmaturia with oxalates. This frequent association of these two affections effectually separated such cases from those mentioned by Mr. Cripps, the patients in the former not necessarily having a weak circulation. A few male patients of his own had suffered from the disease in a more or less chronic form for seven or eight years. The fingers varied with the weather, being always best in summer, and were more or less gangrenous, the tips of two or three being quite lost. Dr. Southey, in reply, said that Raynaud's view of vaso-motor disturbance was probably accurate, but the etiology was very obscure. Local asphyxia was commoner than gangrene, the attacks often lasting a very short time only.

Among neurotic affections may be included a case of "SUDDEN CHANGE IN THE COLOR OF THE HAIR AND SKIN," brought before the Academy of Medicine in Ireland on February 16 by Dr. Smyly (*Dublin Medical Journal*, March, p. 262). An infant, quite well till four months old, had an abscess in the left temporal region, followed by paralysis of one side, but ultimate recovery. One morning, the hair

on the *right* side of the head was found to have undergone a remarkable change from its original brown color to a reddish-yellow. The right eyebrow was similarly affected, and the skin of these parts and of the right hand was yellow; the pillow was also saturated with reddish-yellow perspiration (chromidrosis). The author suggested that the abnormal sweat not only died the hair, but also discharged its normal color. In the discussion, Dr. Walter Smith related the case of a boy in whom the skin of the lobes of both ears and the back of the neck was a sulphur-yellow, the downy hair being bright-yellow, while the hair of the head was brown. The yellow color was easily removed from the hair by a moistened cloth, but no washing, nor ether and chloroform had any effect on the skin. He referred to a case related by Darwin in which the hair of a criminal brought out for execution turned white in the presence of the spectators, but he did not agree that the sweat had any bleaching power.

An interesting case of "MORPHEA in the region of the fifth nerve, with paralysis of the intraocular branches of the third," was communicated to the Clinical Society on May 11, by Messrs. Nettleship and Higgens. A married woman, aged thirty-five, applied to Mr. Nettleship, in 1880, with mydriasis and partial cycloplegia of the left eye, with some dilatation of the retinal vessels and thickening of the coats of the retinal veins. She also had single patches of ivory-white morphea on the corresponding temple, side of nose, and upper lip, and a similar, but less characteristic change in the skin of the forehead and front of the scalp on the same side, with thinning of the hair; the eye symptoms had lasted three months, but she had not noticed the skin changes. She was out of health from parturition and old uterine affection, but there was no evidence of syphilis. She used eserine and took various drugs, including arsenic and iodide of potassium, for a year, and then came under the care of Mr. Higgens, when she continued the same local treatment, and got mercury with iodide. The symptoms of the left eye were unaltered, except temporarily, by the eserine drops. The morphea patches had become partially atrophic, and the hair on the affected area had nearly all fallen. Latterly, there were threatenings of a similar affection of the right eye and right side of face, and a patch of morphea had come over the left scapula; eczema behind the left ear and on the palm of the left hand had appeared during the course of the case; otherwise the patient was unchanged. The authors pointed out that the morphea of the face was strictly confined to territories supplied by the first and second divisions of the fifth nerve, while the eye symptoms pointed clearly to affection of the branches of the third to the interior of the eyeball; in this respect, the case might be compared to cases of zoster of the fifth in which the third or other motor nerves were also affected.

The following case was communicated, on February 19, to the Medical Society of London, by Dr. Heath Strange, as "ELEPHANTIASIS." A girl, aged seventeen, who had been under observation since infancy, suffered from dilated lymphatics of the left lower extremity, leading to great enlargement of the thigh, calf, and foot, and accompanied by the discharge of a milky fluid from ruptured vessels in the thigh. The swelling, which was painless, began in the calf when she was seven years old, and gradually extended to the thigh and foot; it diminished two years later, but soon returned with attacks of pain, heat, and redness of the leg, and severe constitutional disturbance. The skin became darker, nodular patches formed on the dorsum of the foot, roots of toes, inner ankle, and edge of inner side of sole; a small opening appeared on the inner side of the thigh from which a milky fluid was discharged, often ejected with considerable force, and later a similar discharge took place from

the foot; the leg became much swelled, and then, after severe inflammation and great pain in the knee, "something gave way," the pain ceased, and the swelling gradually decreased. Although there had been no discharge for the past five months, the swelling was now much lessened. She was treated by rest, bandaging, good diet, cod-liver oil, and iron. Sir Joseph Fayrer said that true elephantiasis is the local expression of a constitutional disease, and is limited to certain tropical regions and their sea-board, not extending far inland. He doubted a filarial origin of the complaint, as these worms were often absent; he had never known local treatment of any avail, except in very young people. The disease occurred very seldom in persons of unmixed European blood. In some cases, removal to a drier climate had done good; he had tried ligature of the femoral without success, and only temporary reduction followed bandaging; in elephantiasis scrofi, excision often removed the constitutional disease. Mr. E. Owen thought these cases of hypertrophy due to chronic inflammation of the lymphatics had merely a superficial resemblance to true elephantiasis. Mr. Bryant thought he had seen the true disease in a man who had never left England, and in two boys, sons of a West-Indian, but brought up in England.

Dr. Tyson showed a case of "LEPRA TUBERCULOSA" to the Clinical Society, on April 27, in a boy aged sixteen, born in Ireland, who was in India from the age of two months to six years, when he returned to Ireland, and had not been abroad since. The disease had existed only two years, and was well-marked, but presented no special point of interest; bacilli were found in excised portions of the affected skin.

Two important cases of "SARCOMATOUS ULCER OF THE BACK" were communicated to the Pathological Society, on April 7.

Case 1, by Mr. Davies-Colley, occurred in a single woman, aged twenty-nine, in whom there was no history of malignant disease or syphilis. Six months before admission, she noticed a tumor in the gluteal region, and another in the lower lumbar region; the former soon became ulcerated, with a red inflamed edge, the lower part being covered with a slough of skin; a third tumor subsequently developed just below the gluteal ulcer. She was treated by mercury and iodide of potassium without benefit, and died exhausted in two months. The necropsy showed that the subcutaneous tissue at the edges of the ulcer and tumors was infiltrated with a soft, grayish material, and that there was some softening of the third lumbar vertebra, but no distinct inflammation. All the growths were composed of a delicate reticulum, containing a large number of round cells of which a few were multinucleated. The growths were apparently not gummatous, nor tubercular, as there was no tubercle in the viscera; they might therefore be classed as lymphosarcoma.

Case 2, by Dr. F. Taylor, was that of a man, aged forty-two, who first applied with symptoms like those of insular scleroses, which had only been present a few months; there was a peculiar bald patch with scaly skin on one side of the scalp; there was no history of syphilis, but he improved with large doses of iodide. Later, a swelling one and one-half inches in diameter, firm, with an abraded surface, appeared on the back, and another on the inner side of the right knee. The iodide was first increased and then stopped altogether, but the swelling on the back grew rapidly and ulcerated, while that on the knee gradually subsided and disappeared. A number of apparently erythematous patches appeared on the limbs, some of which sloughed, and others ulcerated. Calomel baths were tried, but without benefit; a large superficial slough separated from the tumor on the back, and this was followed by fever, albuminuria, dropsy, and death. At the

necropsy, no disease of the nervous system was found, but the skull was thick, and the pericranium thickened in two places; the larynx was deeply ulcerated, and there was acute nephritis and pericarditis. The lesions of the skin looked in places like boils, and in others were small sloughs; the tumor of the back was firm and hard at the base, yielding little juice on section, and had infiltrated the surrounding tissues: the microscope showed large oval or round cells with a fine reticulum; the epididymis was enlarged and infiltrated by a similar growth. The absence of any history of syphilis, the microscopic appearances which were not those of gumma, and the fact that the testis was not affected, seem to negative this disease; there was no reason to suppose tubercle, so that lymphosarcoma appeared to be the correct view. In the discussion, Mr. A. Durham (chairman) said he had seen the case and thought it quite unusual; he mentioned an instance in a young girl with similar peculiar ulceration and sloughing of the neck, in whom the abdominal glands were found enlarged post mortem, but the examination was incomplete. Another case he remembered was that of a man in whom a large number of small tumors appeared gradually in various parts of the skin, and slowly enlarged; some sloughed, and others ulcerated, and examination showed them to be more or less distinctly sarcomatous. He would prefer, however, to consider such unusual cases as non-descript, until the examination of a larger number permitted a more accurate classification. Dr. Pye-Smith was satisfied that Dr. Taylor's case was not syphilitic, and thought the sloughing somewhat resembled that occurring in carbuncle; he had only seen one case at all similar, where a number of little patches appeared in the skin which looked like purpura, but gradually enlarged, and became distinctly sarcomatous. Dr. Stephen Mackenzie mentioned the case of a man with large masses of glandular tumors in the neck, and a peculiar ulcer on the front of the chest, which was considered lymphosarcomatous; he had seen another case where there was no ulceration, but in which hundreds of lymphosarcomatous tumors developed in the skin of a man with anæmia and hemorrhages in the retina and other organs. Mr. Bendall referred to the case of a man with large flat, oval tumors on the chest back, and head, many of which were ulcerated; he had several attacks of erysipelas, and some of the tumors disappeared, while in others the ulcers healed; he died eventually, and one of the tumors was found to consist of a small-celled growth. Mr. Butlin doubted whether these tumors should be looked on as malignant, or whether they occupied an intermediate position between them and the infection tumors: some of the facts seemed to agree with the latter hypothesis, and the disease might be due to a micro-organism. This question had been raised by Cohnheim in certain lymphosarcomata, and he was quite prepared to believe that some cases, at least, were caused in this way.

In a "Note on the TREATMENT OF WARTS of the genitals by chromic acid" (*Edinburgh Med. Jour.* April), Dr. Cadell advocates the application of this remedy, gr. 100 to $\frac{3}{4}$ i. of water, and finds that the warts disappear with marvellous rapidity, the pain being much less than that caused by other escharotics.

A paper on "the mercurial and non-mercurial TREATMENT OF SYPHILIS," by Dr. Park (*Glasgow Med. Jour.*, March, p. 189), strongly advocates the administration of mercury in all stages, including late tertiary lesions; he admits the value of iodide of potassium in the latter, and also thinks sarsaparilla of some use.

As the result of "Six years' experiment in the TREATMENT OF SYPHILIS" (*Med. Press*, April 18, p. 335), Dr. C. Drysdale, after fully discussing the plans of Ricord, Fournier, Diday, Sigmund, Zeissl, and especially Keyes, concludes that treatment should be continued from the appearance of the initial lesion, very small doses of

mercury being continued "for months." In severe symptoms, inunction or calomel vapor baths are recommended, or fractional doses of mercurial salt should be given for a week or so every four hours, in combination with large doses of the iodides of potassium, sodium, or ammonium. In gummy deposits the chief remedy is iodide of potassium in large doses, but a tonic dose of some mercurial salt may be added; he agrees with Keyes in regarding minute doses of mercury as tonic, and says they may be given even for years with advantage in some cases of anemia.

LONDON.

CAVAFY.

Selections.

ON THE CONSTITUTIONAL TREATMENT OF THE EARLIEST SYMPTOMS OF SYPHILIS.

THE theory that the initial sclerosis is a sign of the already finished general infection has for its chief basis the negative result obtained by inoculations on the patient himself. This apparently unimpeachable maxim is nevertheless open to several objections. Even if it were a fact that auto-inoculation always gave a negative result, this might be explained in this way, that by the time the incubation of the inoculated virus is ended, and the second sclerosis should be developed, the total organism had been infected from the first sclerosis, and it does not prove that this general infection existed when the second inoculation was performed.

Furthermore, there are exceptions to the rule that auto-inoculations are negative. Cases have been observed, *e. g.*, by Boeck and Bidentkap, in which the inoculation of syphilitic persons after a regular incubation gave rise to a regular sclerosis exactly as on non-syphilitic individuals. Dr. Pontoppidan has himself observed the formation of a late abortive formation of papules on the inoculated places. In several instances, the punctures at the end of two weeks became the seat of red, elevated, hard, sometimes slightly scaling papules, from the size of a pin's head to a hemp seed, which disappeared when the constitutional symptoms became developed.

He compares the development of syphilis to that of cancer and tuberculosis, which from local diseases become general diseases, and thinks that if this be so, a general antisyphilitic treatment, as long as only the initial sclerosis and adenitis are present (so-called second incubation), can only have value as a preventive of general syphilis. In so important a question, however, it is not safe to be guided by theories alone. He tries therefore to solve the question about the significance of the initial sclerosis from a practical standpoint by examining the influence of the constitutional treatment on the early manifestations of syphilis. He was enabled to do so by the circumstance that the former physician-in-chief, Dr. Engsted, used to commence the general treatment immediately on the appearance of the initial sclerosis, or at least when that and the consecutive glandular swelling became manifest, while the present physician-in-chief, Dr. Haslund, remains expectative, and limits himself to local treatment until the general symptoms appear. As the old histories of cases were not written with the elucidation of

this point in view, the author has only found a limited number of them available for comparison. He divides them in three groups:

I. Eleven cases treated with inunction during the whole of the second incubation:

Length of incubation, average,	27 days.
Number of inunctions before the appearance of spots,	25 "
Duration of treatment after that,	33 "

II. Thirty cases treated with inunction during part of the second incubation:

Length of incubation,	31 days.
Inunctions before efflorescence,	13 "
Duration of treatment after that,	36 "

III. Thirty cases which exclusively received local treatment during the second incubation:

Length of incubation,	29 days.
Duration of treatment after the appearance of the exanthem,	29 "

In twelve cases of the first two groups, the appearance and vanishing of the spots were noted. The duration averaged twenty-one days; in fifteen cases of the third group it was nineteen days.

The cases which were treated expectatively have not been under observation during the whole course of the disease. In four cases in which Dr. Pontoppidan observed the formation of the induration, the appearance of the eruption took place on respectively the twenty-second, twenty-eighth, thirtieth, and seventy-eighth day. In eleven cases in which he could follow the syphilides from their appearance till their disappearance, the duration of the exanthem was nineteen days on an average. The course of the cases which received no specific treatment seemed to be as light and simple as that seen where it is used.

The author thinks that both theoretical reasoning and practical observation lead to look upon syphilis as a general exanthematous disease which starts from a local focus: has, like other exanthematous infectious diseases, a rather typical course, at least in its earlier stages, and, like them, is little amenable to treatment in its first, subacute, and more regular stage. An early specific treatment would therefore scarcely be indicated, at least not in so far as the first syphilitic manifestations themselves are concerned. In conclusion, he recommends to give the expectant treatment a fair trial.—PONTOPPIDAN, *Hospitals-Tilende*, March 28, 1883.

PATHOLOGICAL ANATOMY OF LUPUS.

At a meeting of the Société de Biologie, MM. Vidal and Leloir exhibited some beautiful histological preparations of different forms of lupus. Careful study of these specimens has authorized them to transfer to the class *lupus* a cutaneous affection commonly described as belonging to a different nosological division, viz., the warty scrofulide. *Lupus tuberculosus non exedens* is characterized by an infiltration of embryonic cells into the superficial portion of the derma, and even into its middle and deeper layers. These cells are aggregated into primary nodules, which again are brought together so as to constitute secondary nodules, exactly as in the case of tubercular follicles and miliary tubercles. These nodules are composed of small cells in the midst of a very delicate network, and each of them is encircled by a wreath of embryonic elements interspersed with giant cells.

The subjacent epidermis is thickened and divided into "colonettes," which at first sight might be taken for nuclei of epithelioma. The lupus ulcer is developed

from a phlyctena, which is itself produced by the coalescence, at some point of the mucous layer, of epithelial cells distended with serum.

The anatomical structure of lupus is thus seen to bear a singular resemblance to that of tubercle. Is this because they are both dependent on the same constitutional malady, tuberculosis? MM. Vidal and Leloir do not think so, for the reason that they have never met with a case of genuine tuberculosis of the skin which has developed any peculiarities as to progress or duration. Besides this, there is abundant clinical evidence showing an essential difference between the two morbid products; for instance, lupus of the throat may almost be called indolent and painless when compared with pharyngeal tuberculosis.

No results have been obtained from the experimental inoculation of animals with lupus. The anatomical likeness between tubercle and lupus may be traced even into their ulterior stages of development: thus, the warty scrofulide (called by authors *lupus sclerosus*) corresponds to fibrous tubercle.

Erythematous lupus, which the Vienna school regards as the result of a simple chronic inflammation of the skin, belongs to the class *lupus* by its etiology, its mode of development, and its pathological anatomy. In this form, the infiltrated embryonic cells are not collected into nodules, but are diffused throughout the superficial layer of the derma, and in this situation degenerate and perish. The accumulation of new elements which takes place around vessels and glands obliterates the ducts of the latter, causing them to assume the appearance of whitish grains filled with sebaceous matter.—*Le Progrès Médical*, November 25, 1882.

KELOID AFTER SCRAPING FOR LUPUS.

THE patient, a boy, was shown (at the Pathological Society of London) by MR. CLUTTON. He originally presented a patch of lupus in front of the ear: this was scraped in April, and in July it was perfectly healed. Subsequently, an abscess appeared behind the shoulder-joint, which was opened, and a sequestrum removed, leaving a large cavity. This incision healed quickly by first intention. Early in November, the cicatrix on the right cheek had passed into the condition of keloid, and the scar of the incision over the humerus was also enlarged and keloid. This condition had persisted up to the time at which the patient was examined. Another similar incision made over the head of the tibia had not taken on the keloid change, whereas, a scar left by the amputation of a phalanx had become thickened, and was apparently about to become a keloid.—MR. LUCAS had seen keloid in several cases after scraping for lupus, and had always found that the condition spontaneously recovered after some time. At the time the keloid developed, in one case he had seen, the patient had rapidly improved in health, and he had attributed the development of the keloid to this.—MR. BUTLIN pointed out that the patient shown was strumous, and in such patients scars had a tendency to enlarge. He thought that, not improbably, Mr. Lucas would find that though the keloid growth in his patient occurred when the patient's health was improving, yet, when the health was still further improved, the tendency to overgrowth of the scar-tissue would diminish.—MR. MORRANT BAKER had recently excised a large patch of lupus, where the wound healed well, but subsequently became keloid; the disease in this case was lupus hypertrophicus, and possibly that might have been the case also in Mr. Clutton's case; if it were eventually found that it was only in the hypertrophic form of lupus that this outgrowth of the scar was likely to occur, that would be an important clinical fact.—MR. BALMANNO SQUIRE had found keloid a very common sequence of erosion of

lupus. The treatment of lupus by linear scarification was never followed by the occurrence of keloid. As a rule, the keloid eventually disappeared, but this was hastened by scarification. Was the patch of lupus in this case primary, or was it secondary to suppurating gland in the neck?—MR. SUTTON said that the late Mr. Critchett always used to maintain that the history of the scar had never been completely written, founding his remarks on the extreme vascularity of the scar after peritomy in serofulous subjects.—MR. CLUTTON, in reply, thought that, though a thick scar was a common result after the healing of a strumous ulcer, yet keloid, such as had, he thought, undoubtedly developed in his case, was rare. The case was not one of lupus hypertrophicus, but of lupus vulgaris, and was, in its origin, in no way connected with any gland or suppurating sinus.—*Brit. Med. Journ.*, Jan. 20, 1883.

MALIGNANT PUSTULE COMMUNICATED BY A FLY.

A SOMEWHAT remarkable case is reported in the *Gaz. des Hôpitaux*, No. 102, for Sept. 5th, as having occurred in the service of M. Mollière, surgeon-in-chief to the Hôtel Dieu at Lyons. The patient was bitten on the cheek by a large black fly which he immediately killed. The bitten spot in a few hours began to itch violently, but no swelling appeared until the next day. When the patient entered the hospital the whole cheek was of a livid color and enormously swollen, especially over the malar bone, the centre of which region was occupied by a small black phlyctena surrounded by a number of transparent vesicles. The eyelids were considerably swollen, and one of the submaxillary glands was enlarged and tender. There was no fever or other constitutional symptom. M. Mollière's treatment was prompt and energetic. He first completely destroyed the pustule by means of the thermo-cautery, and then injected the swollen parts, including the submaxillary gland, with a twenty-per-cent solution of phenic acid. The only internal remedy employed was alcohol, which was administered in enormous quantities without producing the slightest sign of intoxication. The affected surface began to slough off on the third day, and in another week was entirely detached. The healing process proceeded rapidly, and at the end of three weeks the patient was discharged. Blood and serum drawn from the vicinity of the pustule having been forwarded to an eminent expert for examination, he succeeded in detecting a few filaments of the bacillus anthracis, and a cobaye which was inoculated with the fluids died in a few hours with all the signs of specific gangrenous infection.

PERFORATING ULCER OF THE FOOT AND PROGRESSIVE LOCOMOTOR ATAXY.

PROF. BALL and M. THIBIERGE, in a paper read before the recent International Medical Congress, have endeavored to show that there is a direct connection between perforating ulcer of the foot and locomotor ataxia, and bring forward twelve cases to demonstrate that circumstance. They assert that the foot sore may be one of the earlier or premonitory symptoms of the cord disease, or on the other hand, it may prove one of the late or terminal manifestations. The correctness of this important conclusion is disputed by Mr. Treves, who details a case then under his care that would appear to bear out the assertion just referred to, but in which he argues that the ataxic symptoms were only casually connected with the perforating ulcer of the foot by which they were preceded. He mentions having had during the last few years three patients with perforating ulcers on the soles of their feet that resisted treatment, but were unaccompanied by any evidence of nerve-affection of any kind.

He urges, therefore, that the so-called "perforating ulcer" is a purely local affection produced by purely local causes, which causes would act with increased vigor upon a part whose vitality is in any way impaired, but that that impairment is not of necessity dependent upon disease or degeneration of the supplying nerves. The relation of the malady, therefore, to locomotor ataxia would appear to be of no more clinical value than would be a burn on the sole of an ataxic subject who had unconsciously brought his boot in too close contact with fire.—*Lancet*, Oct. 21, 1882.

ON THE ELIMINATION OF MERCURY FROM THE HUMAN SYSTEM; WITH ESPECIAL REFERENCE TO "GLYCOCOLL-HG."

THE subjects of the author's investigations were fifty-one cases of syphilis treated by him at Prof. Wiegner's clinic in Strasburg during the fall of 1881 and in April, 1882. Of these cases, twenty-one were treated by hypodermic injections of different mercurial preparations; ten received mercurial inunctions; in nineteen cases a mercurial course had been completed before the urine was examined; and in one case *hydrarg. biniod. rubr.* had been previously administered. In seventeen out of the twenty-one cases constituting the first class, *glycocol-Hg.* was employed for the injections.

The general conclusions arrived at are summed up as follows:

I. Mercury can almost always be detected in the urine within twenty-four hours after an injection of *glycocol-Hg.*; while, if gray ointment be employed, from eight to twelve inunctions must be made before the metal is discoverable.

II. In order to determine whether treatment in any given case has been followed by excretion of the mercury, it is necessary to examine the urine for several days in succession—since such excretion is well ascertained not to be a constant result—or else (as recommended by Schneider) to analyze at once the whole amount of urine voided during a like period, the quantity of mercury excreted within twenty-four hours being very trifling.

III. Mercury may be found in the urine two months after the subcutaneous injection of *glycocol-Hg.*, but never at a later period, even in the aggregate amount of several days' secretion.—*Inaugural Dissertation*, by J. NEGA, Strasburg, 1882.

TREATMENT OF GONORRHOÆAL EPIDIDYMITIS.

DR. HENDERSON reports the successful use of salicylate of sodium in three cases of this affection. In conclusion, he says: "In further trials of this plan of treatment, I would advise that only acute cases be selected, the evidence of that condition being a distinct rise of temperature as ascertained by the thermometer. The dose of the salt should not be less than twenty grains, and should be repeated hourly until at least three doses are taken; afterwards the same dose may be continued at longer intervals.—*Lancet*, December 16th, 1882.

TREATMENT OF ERYSIPELAS OF THE FACE.

ROTH has revived Wilkinson's old method of treating erysipelas, and Unna reports a case so treated. The method consists simply in giving every two hours a tablespoonful of a mixture of eight parts of carbonate of ammonia with two hundred and ten parts of any convenient menstruum. Unna's case was severe with high fever, sleeplessness, and delirium. In twenty-four hours the affection was under control, and amendment had occurred, and in three days the patient was well. No external applications were employed.—UNNA, *Monatsh. f. Prak. Derm.*, October, 1882.

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Original Communications.

ON THE ELIMINATION OF MERCURY DURING AND AFTER ITS
CUTANEOUS EMPLOYMENT.

BY
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SINCE 1881, I have made a series of more than one hundred examinations respecting the elimination of mercury in syphilitic patients who were either still under treatment by mercurial inunction, or had been treated thus for some longer or shorter time (one to twelve years).

Most of the patients had practised inunction with mercurial ointment; in a few, in whom, after twenty or thirty inunctions with blue ointment, no mercury was found in the urine, so that it might have been supposed that the mercury did not penetrate through the skin into the organism, subcutaneous injections of mercury were given at the same time, so as to make sure of the presence of this substance in the system.

In a few cases, besides, the French solid mercurial soap (*savon napolitain*) was used. I shall here anticipate by stating that, after employing twelve inunctions with this soap, mercury was found in the fæces; I shall add, too, that I nevertheless employ the soap but seldom for general treatment, because it cannot be equally well rubbed up as blue ointment (*unguentum hydrargyri cinereum*).

At first only the urine was tested for mercury, each time one litre of urine, never any smaller quantity. The method of examination was that

of Ludwig-Fürbringer, as modified by Schridde. The urine having been mixed with muriatic acid, so as to destroy all organic substances present, brass wool—*i. e.*, filaments of copper (lametta)—is added; hereby any mercury in the urine, by forming an amalgam with the copper, is separated. After having been left at rest for some time, the lametta is taken out, washed on the filter with water, then with alcohol and finally with ether; rolled up it is then thrown into a potash-glass test-tube, and heated; any mercury present is thus sublimed at a cold part of the tube. The lametta is removed, and a trace of pure iodine is introduced into the test-tube and heated; the iodine vapors then unite with the hydrargyrum to form iodide of mercury, and a bright-yellow to fine carmine-red deposit proves the presence of mercury. Prof. Ludwig recommended zinc powder; but as the latter generally contains arsenic, and as arsenic gives with iodine a combination of similar color to hydrargyrum with iodine, zinc powder was not used in our experiments.

During the above-mentioned examinations of the urine for mercury, the latter was often found in small, rarely in large quantities, and not only during, but also some weeks after the mercurial treatment. Frequently, however, the mercury was *not* found in the urine, either during or after the treatment, especially in those cases where it would have been particularly expected, from the quantity employed for a long time.

From this it followed:

1. Mercury is irregularly eliminated by the urine—a result pointed out already by the Siegmund school (comp. Vajda and Paschkis: “*Ueber den Einfluss des Hydrargyrum auf den Syphilis-Process*,” Vienna, 1880, mit einem Vorwort von Prof. Ludwig und Siegmund).

2. The mercury introduced by inunctions either

- a.* Remains stored up in the organism—a view held by the above-named authors; or else,
- b.* It is excreted in some other way.

I therefore proceeded to the examination of the feces, and found that it was always present in large quantities.

In most cases, the feces of a single evacuation were examined; they often weighed barely one pound.

The method of examination was the following:

The feces were first mixed with five grams of bromine; they were thus disinfected; they were then evaporated to a thick pasty mass. To this paste were added concentrated nitric and hydrochloric acids, in order to destroy organic substances, and the whole evaporated to dryness, until *all* the acid was completely expelled. The dry mass was mixed with hot water, and filtered. In the filtered fluid, the mercury was detected in the same way as in the urine.

The result of the forty fecal examinations was the following:

Mercury was found regularly in relatively large quantities during the course of inunctions (the earliest examination was made ten days after the beginning of the treatment).

Mercury was found in the faeces for five and one-half months after the end of the course; during this time, it was found regularly in the fecal examinations made at intervals of ten to fourteen days.

Mercury was found in the faeces in all the cases in which it was found in the urine; on the other hand, it was frequently not present in the urine where it was found in the faeces.

After prolonged courses of inunction, mercury was found in the faeces at times in such considerable amount that it could have been determined quantitatively.

From this it follows:

1. The elimination of mercury by the faeces is regular, continuous.
2. The elimination of the mercury introduced after more extensive courses of inunction, say of from thirty to forty-five days, is completed in six months.
3. Accordingly, persistence of mercury in the organism does not occur.

It might be supposed that, when mercury is regularly eliminated by the faeces, this should also take place by the urine; possibly, if large quantities of urine, say two or three litres, were examined each time, mercury might be found regularly, even if but in traces, in cases where it was not found before.

It might be possible that mercury will be found in the faeces even eight months after a very prolonged course of treatment. But then, too, its excretion remains limited in time.

In a large number of patients who had been under my care eight months and one year before, and who had been under mercurial treatment elsewhere for from two to twelve years, I have had both urine and faeces tested for mercury, but it was not found in any case.

It is possible that some one or other may have found mercury in the faeces previous to my examinations. But my investigations show not only that mercury is eliminated by the faeces, but also that mercury is regularly, continuously eliminated by the faeces, and that this elimination reaches its end at a time to be determined according to the duration of the course of inunction.

This disposes of all the conclusions drawn from the supposed permanence of mercury in the organism on late syphilis.

In the above-mentioned book of Vajda and Paschkis are enumerated, as proofs of the permanence of mercury in the organism, cases in which these investigators claim to have found mercury in the urine, two, three, five, seven, thirteen years after the use of relatively short courses of in-

unction. Admitting the fact that the mercury has been demonstrated, it does not follow that the mercury found in these cases was that introduced into the system two, three, seven, and thirteen years before.

These last-mentioned cases were those of patients (l. c., p. 302) several of whom remained as long as thirteen days in Siegmund's syphilitic ward before their urine was tested for mercury; hence who were for several days, to the number of thirteen, in the same room with from twelve to twenty patients—a fact which will be confirmed by any one who had the good fortune to visit Siegmund's ward—nearly all of whom used daily inunctions of mercury. It is certain, therefore, that with the air of the room they inhaled the easily volatilized mercury present in it; and if the authors named have found mercury in the above-mentioned cases, this was probably derived from the mercury inhaled during the two to thirteen days, but not from that introduced two to thirteen years previous.

To be sure, the above-named authors have filtered air impregnated with mercury (l. c., p. 306) through cotton saturated with silver nitrate; but they found no mercury in that cotton. But this does not prove that patients in hydrargyricized air do not inhale any mercury.

Dr. Lesemann, in a report on 144 patients under his care in the syphilitic ward of the Kalinkin Hospital at St. Petersburg (*St. Petersb. Med. Wochenschr.*, March 13, 1883), states that during the inunctions exclusively used, despite the small quantities of unguentum hydrargyri cinereum employed (℥i.—℥ss.), stomatitis was of frequent occurrence, not only in those under treatment, but also “in patients to whom no mercurial preparation was given, so that the affection could only be ascribed to the effect of the mercurial vapors accumulating in the wards, which cannot be removed by ordinary ventilation.”

From the results obtained by me, namely:—

1. That mercury introduced in the organism through the skin or in any other way is eliminated continuously;

2. That this elimination in the ordinary mercurial treatment is completed after the lapse of six months;

3. That, therefore, there is no persistence in the organism of the introduced mercury:—

important conclusions may be drawn relative to the certain treatment of syphilis.

As to the latter, I shall be glad to avail myself of the pages of the JOURNAL at some future time.

THE TREATMENT OF ECZEMA.

BY

McCALL ANDERSON, M.D.

(Continued from page 340.)

IN *infantile eczema*, we must carry out the same principles of treatment as in the adult. As a rule, however, bearing in mind the tenderness of the skin of young children, and the sensitiveness of their nervous systems, soothing are generally preferable to stimulating applications, and in any case powerful local stimulation is to be avoided. The diet should be carefully regulated, and if there is any digestive derangement, an occasional dose of gray powder, or from half a grain to a grain of calomel (in children from nine months to two years old) is often of service. In chronic cases, and when the digestive and other organs are in a satisfactory state, arsenic frequently yields most excellent results, given with the precautions already mentioned. It will thus be seen that our experience is entirely at variance with that of Hebra, who says: "When it involves the scalp and face, whether of healthy infants or those affected with scrofula, rickets, anæmia, or any other constitutional complaint, the treatment should always be strictly local; for experience has not yet given us any internal medicine which is of the least use in these cases."¹

In chronic cases, the parts may be washed with tar or cade soap, or sponged with a dilute tar wash, such as half an ounce of liquor carbonis detergens, mixed with six ounces of distilled or rain water, or a mild mercurial ointment, mixed with one of the above preparations, may be used.²

From the treatment of eczematous eruptions occurring in limited patches, we pass naturally to the consideration of the last division of the subject, namely, the *local varieties of eczema*; but it must be observed at the outset that the remarks about to be made are to be taken in connection with what has already been stated, as much needless repetition may thus be avoided.

¹ "On Diseases of the Skin." By Ferdinand Hebra, M.D. Syd. Soc. Trans., vol. ii., p. 160.

² R Ung. hydrargyri ammoniati..... 3 iss.
 Hydrargyri subchloridi..... gr. v.
 Olei cadini..... ℥xx.
 Glycerini (Price) ... 3 i.
 Ung. simplicis..... 3 vss.

While eczema may be seen upon any part of the cutaneous envelope, and, indeed, may affect *almost* the whole of it at one time, there are certain localities which it seizes upon in preference to others, and to which it is often limited. These are the head, hairy portions of the face, lips, edges of the eyelids, nostrils, external auditory passages, and ears, hands, feet, legs, genitals, anus, breast, umbilicus, flexor surfaces of the joints, and those parts of the skin which are naturally in contact with one another.

Eczema of the head (eczema capitis, impetigo capitis) occurs most frequently in the pustular form, especially in the case of children, whose heads are attacked with remarkable frequency, and next to this in the dry squamous form, particularly in chronic cases. When this part is affected, the eruption has a tendency to chronicity, particularly if the treatment is not energetically and thoroughly carried into effect, for it is more difficult to keep the surface clean than when the non-hairy parts are invaded, owing to the hairs being glued together by the exudation, and to the crusts being entangled in them, and being difficult of removal. For this reason, the patient often allows them to remain for weeks, months, nay, even years, upon the head, and when advice is at last obtained, the whole scalp is not unfrequently found to be concealed from view. In this way, collections of pus are apt to take place between the crusts and the scalp, owing to the confinement of successive exudations, and do infinite harm. Besides, when hard crusts are allowed to remain on the head for a lengthened period of time, they press on the hair follicles, and lead to their obliteration; whereas, when the eruption is properly treated from the first, there can be no permanent loss of hair. The crusts are composed not merely of the morbid secretion, but also of the contents of the sebaceous glands, which in this situation are very abundant; and thus, in neglected cases, owing to the products of decomposition, the disease is calculated in an eminent degree, not only to offend the eye, but also the sense of smell. When neglected in the manner just indicated, lice are attracted to the part, and are often detected wallowing in the mire in thousands, while their nits (eggs) adhere by means of sheaths with great tenacity to the hairs, and in countless numbers. The careless observer is very apt to mistake the scales which are often scattered through the hair for the nits of pediculi, but the latter are smoother and more egg-shaped, and adhere to the hair with great tenacity. The use of a low power of the microscope would, of course, at once settle the question. But while lice often occur as complications of an eczematous eruption, we must be alive to the fact that these insects sometimes attack the head of a healthy person, in whom they excite a sensation of itching. This causes the patient to scratch the part, and an eczematous eruption may thereby be induced. The lice

on the head are thus the exciting cause of eczema in some cases, its result in others.

Little subcutaneous abscesses are sometimes met with on the head, especially in children, and enlargement of the neighboring glands, especially of those on the back of the neck and over the mastoid processes, occur in all aggravated chronic cases.

In the later stages of the disease, when the crusts have fallen and the exudation has ceased, the disease assumes the form of eczema squamosum, the scalp being red, scaly, itchy, and infiltrated. In all cases of old standing the hair falls out to a considerable extent, but the thinning of the hair, with the exception already mentioned, is only temporary; for it grows again as well as ever after the skin affection is removed. The eruption may occur in patches scattered over the head, or the whole of the scalp may be attacked, and often neighboring parts also, especially the nape of the neck, the mastoid processes, and the ears.

The *diagnosis* of eczema capitis is sometimes difficult to the unaccustomed eye, and I have accordingly arranged in a tabular form the points to be attended to as distinguishing it from the so-called syphilitic eczema capitis, seborrhœa capitis, psoriasis capitis, and tinea tonsurans:

Table showing the Points which Distinguish Eczema capitis from Syphilitic Eczema capitis, Seborrhœa capitis, Psoriasis capitis, and Tinea tonsurans :

<i>Eczema capitis.</i>	<i>The so-called Syphilitic Eczema capitis.</i>
1. Occurs oftenest in children.	1. Occurs usually in adults.
2. Often attacks the whole scalp.	2. Usually occurs in small patches.
3. Itching often severe.	3. Usually absent.
4. Exhibits superficial ulcers only, if any.	4. May exhibit deep ulcers, with perpendicular edges, and unhealthy bases.
5. Occurs in persons in whom there is no history of primary syphilis, except as a coincidence.	5. Occurs in persons from whom a history of primary syphilis may be obtained.
6. Does not occur in connection with symptoms of syphilis, except as a coincidence.	6. Occurs usually in connection with other signs of syphilis, <i>e. g.</i> , alopecia, sore throat, other syphilitic eruptions on the skin, nocturnal pains, etc.
<i>Eczema capitis.</i>	<i>Seborrhœa capitis.</i>
1. Exhibits crusts which are brittle, are often very thick, and are composed of pus, granular matter, and epithelium.	1. Exhibits crusts, which can be kneaded into a ball, are usually thin, have an oily feel, and are composed principally of sebaceous matter and epithelium.

2. Is excessively itchy; and after removing the crusts, the scalp is infiltrated, red, often excoriated, and exudes serum or pus.

Eczema capitis.

1. Occurs oftenest in those whose health is below par.
2. Edges of patches not abrupt, but gradually shading off into the healthy skin.
3. Is usually very itchy.
4. Often moist and exuding.
5. Exhibits thick, yellowish, usually moist crusts, or, if scaly, the scales are looser and not silvery.
6. Occurs often in connection with eczema of other parts, as of the ears, etc.

Eczema capitis.

1. Patches not circular, although the hair is often cut short in a circular manner with scissors.
2. Hairs healthy (though they may fall out here and there), and exhibit no parasite.
3. Itching usually great.
4. Eczematous eruptions often on other parts of the body.
5. Not contagious.

2. Is not excessively itchy; and after removing the crusts, the scalp is not infiltrated, red, or excoriated, exudes neither serum nor pus, but is smooth and oily.

Psoriasis capitis.

1. Occurs oftenest in those who are apparently in robust health and who are well nourished.
2. Edges of patches abrupt.
3. Is usually not very itchy.
4. Is with rare exceptions a perfectly dry eruption throughout.
5. Exhibits usually white, dry, silvery, adherent scales.
6. Occurs generally in connection with psoriasis of other parts, especially of elbows and knees, where the diagnosis is easy.

Tinea tonsurans.

1. Patches often circular.
2. Hairs often brittle: twisted, or broken off close to the scalp; thickened and often white; loaded with the parasite (*trichophyton tonsurans*).
3. Itching usually slight.
4. *Tinea circinata* often present.
5. Contagious, especially to children, and often other members of the family exhibit ringworm of the head, body, or beard.

But cases are frequently met with in which ringworm of the head is complicated with eczema of the head. The latter is then the more prominent feature of the two, and the ringworm is apt to be overlooked. In these cases the diagnosis is arrived at by detecting the white or black thickened stumps of hairs loaded with the parasite. It is therefore well, in every case of eczema, to examine the hairs carefully with the eye at least. The history of the case, the way the eruption commenced (in circular dry patches), and the evidences of contagion, assist the diagnosis.

The following case is a good example of the complication of ringworm of the head with eczema :

“Richard B., aged eight, was admitted at the Glasgow Dispensary for Skin Diseases, Nov. 25, 1861. Almost the whole of his head was covered with thick, yellow, eczematous crusts, and the backs of his ears were infiltrated, exuding, and itchy. Little patches of alopecia existed on the scalp, and on examining the head attentively, stumps of hairs were detected here and there, which were brittle, broke on attempting to extract them entire, and were loaded with the spores of the trichophyton tonsurans. The disease commenced as a small circular patch on the crown of the head, having, according to the statements of the mother of the patient, all the characters of ringworm.”

Mr. Jabez Hogg is of opinion that parasitic growths are to be found in nearly all kinds of chronic skin diseases, a statement which is entirely at variance with general experience, and I cannot help thinking that some error, such as that against which the reader has just been warned, must have crept into the inquiry.

Tinea decalvans (circular patches of baldness) ought never to be mistaken for eczema of the head, and the disease only requires to be kept in view in order to prevent an error in diagnosis.

Tinea favosa is, however, often difficult of distinction from eczema capitis, unless due care is taken. In cases of favus “where the head is more or less covered with an eruption exhaling the odor of mice, and consisting of bright yellow, dry crusts, depressed in the centre, through the middle of each of which one or more hairs pass, which have a dull, dry appearance, and are more easily extracted than natural, the diagnosis is very easy, and those who have seen the disease once can never mistake it. When, however, it has continued for a length of time, when the crusts have lost their cup-shaped form and their bright yellow color, and have become entangled in the hair; when, in fact, we have to do with the variety described as favus squarrosa, it may be—and often is—mistaken for impetigo of the scalp. But in the former” the edges of the patches are abrupt, and “there are generally patches of alopecia which are wanting in the latter; in it certainly the hairs often fall out, although only here and there, and not in patches as in favus. The alopecia of favus is permanent, that of impetigo generally temporary. There is also no alteration of the hairs in the latter, in the former they are dull, dry, brittle, discolored, and easily extracted. Attention to these points generally serves to clear up the diagnosis; but if doubt still exists, it may at once be removed by the microscopic examination of the hair and crusts. There is one point, however, which requires to be borne in mind, namely, that the discovery of some pustules does not prove that the disease is impetigo, as pustules are frequently developed in cases of favus from the irritation of the parasite, or of the treatment, or from the

scratching in which the patient indulges. And also, one should not lay too great stress on the value, in a diagnostic point of view, of the mouse-like odor exhaled from the eruption in favus, as this symptom is not always so pathognomonic as some dermatologists would have us suppose.

“Very often the diagnosis is rendered difficult on account of the propensity of patients to clean carefully, and remove all the crusts from the head, before bringing their children for advice. There is then to be seen redness of the scalp combined with the presence of a few pustules, the result of irritation; and here again the disease resembles impetigo. But if it is a case of favus which we have before us, the deep red, depressed, distinctly circumscribed surface, covered by a thin, shining epidermis, is quite different from the light-colored, diffused redness of impetigo. If this is not sufficient, the hairs should be examined, when they will be found to be altered, and the parasite is detected in them with the microscope. If this is not satisfactory, do not give an opinion, or resort to any treatment, but desire the patient to return in a couple of weeks, leaving the head untouched in the *interim*, after which time the disease will have had time to re-develop, and its nature is at once discovered.”¹

In the *treatment* of eczema of the head, the removal of the crusts is often more difficult than on non-hairy parts, particularly when the hair is long; but it is not necessary, nor as a rule is it desirable, to shave the head, as is so often done: the means already described for the removal of desiccated exudation being amply sufficient, even when the head is the seat of the disease. But if it occurs in an aggravated form in children, in whom the removal of the hair is comparatively of little moment, I am in the habit of ordering it to be cut short; and I always insist upon this if—as happens too often, particularly amongst the poor—the disease is complicated with lice. The crusts can then be separated with greater facility, the morbid surface is more fully exposed to view, and remedial applications can be more thoroughly applied. A very good way of removing the crusts is to soak the head with almond oil, and afterwards to envelop it in a flannel cap, a method of treatment which also favors the removal of the eruption in many instances. (Hebra.)

The use of one of the tarry preparations already mentioned is specially to be recommended in chronic cases, for, as Hebra has remarked, “the treatment by tar is nowhere so useful as in eczema of the scalp;” but it must be used freely and brought thoroughly into contact with the skin.

In chronic cases occurring in adults, and rebellions to other treatment, the use of a vulcanized india-rubber cap, or shaving of the head,

¹ “The Parasitic Affections of the Skin.” By McCall Anderson, M.D. London: Churchill and Sons. 2d Ed., p. 36, 1868.

and the application of iodine, blisters, etc., is to be recommended. In very obstinate chronic cases, which resist both internal and external remedies, although very few indeed do not yield to blisters, epilation may be tried, though this is rarely, if ever, necessary.

(To be continued.)

THE ETIOLOGY OF ACNE.

BY

HENRY G. PIFFARD, M.D.

BEFORE discussing the topic that is embraced in the title of this paper, it is expedient that there should be a clear understanding of the meaning of the term acne as here used. This name is at the present day employed in a much more restricted sense than formerly, and for the purposes of this paper will be confined to an inflammatory affection of the sebaceous glands, presenting several varieties and grades, while a number of other affections, *e. g.*, the so-called acne sebacea, acne miliaris, acne varioliformis, acne rosacea, etc., are excluded from present consideration. It need hardly be stated that the papulo-pustular syphilide, sometimes termed syphilitic acne, and the various medicinal rashes ("bromic acne," etc.) of an acneoid character do not fall within the scope of the present paper.

From a practical standpoint, successful treatment is the ultimate object of all our researches; and to obtain the best results in this direction, it is as necessary to consider the etiological problems in acne as in most other affections. The greatest measure of success will not be obtained by simply making a nominal diagnosis and treating all cases by one routine plan of treatment, nor can we be guided alone by what may be termed the external symptomatology. This latter plan may, it is true, enable us to banish with commendable speed an existing eruption, but it insures no protection against an early recurrence. What we should really seek to accomplish is removal of the present lesions and prevention of their return. This we have no right to expect to accomplish unless we acquaint ourselves with the causes that, in the first place, induced the occurrence of the eruption, and, in the second place, tend to perpetuate it.

These causes it will be our first duty to investigate, and we will therefore enumerate those which prominent dermatologists of modern times have believed to be of importance. Commencing with English writers, we find that Wilson assigns the following as among the causes of acne:

Disordered state of the cutaneous innervation.

Direct congestion of the integument.

Torpidity of the capillary circulation.

Amenorrhœa.

General plethora.

Partial plethora occurring at the time of the menopause, from exposure of the face to heat; from excesses in diet or stimulating drinks; from the use of cold drinks in a heated state of the body, and from local application of irritating substances, including the abuse of certain stimulating washes and powders employed as cosmetics.

Dr. Tilbury Fox says: There ought to be little difficulty in arriving at a satisfactory conclusion as to the chief conditions which lead to the development of acne, for the simple reason that the disease is so abundantly common, at least in England, as to furnish an exhaustless supply of material for observation on this point. The statement that acne is due to the accumulation of sebaceous secretion in the glands, and perifollicular inflammation excited thereby, is satisfactory as far as it goes; but the reader naturally desires to know what leads to the accumulation of sebum, and what are the influences that lead to the varying character and degree of the perifollicular inflammation. I will mention some of the causes. In the first place, it must be remembered that the circulation of the face is sensitive to irritants; it is liable to great fluctuation; it is very active. These states are acted upon by external, and not only external, but various internal agencies; and nothing is more probable than that some derangement of the vascular supply will frequently take place. Then the glands are particularly well developed in the very situations in which acne is wont to occur—the face, for instance—they are therefore likely to become functionally deranged. All debilitating causes; all local causes of irritation and disorders of those organs which have a reflex relation with the face; want of cleanliness; cold winds; the use of cosmetics, and many other things, may induce glandular congestion, and so acne.

But in addition to this, acne occurs at a time when the hair follicles and their related sebaceous glands are physiologically active, that is to say, at puberty, when there is great development of hair over the body, and naturally much activity of the sebaceous glands. Whenever a portion of the body is physiologically active, it is likely to become disordered if the general or local condition of nutrition is deranged or defective. Physiological activity of the hair follicles implies activity of the blood-vessels and of nerve supply; and if there be local or general debility, what is termed “sluggish circulation,” leading to congestion, may occur, and the action of external irritants, heat, cold, and the like, will operate more effectively as an excitant of congestion than under ordinary

circumstances. Moreover, under the same circumstances, certain disordered conditions of internal organs more readily intensify the congestion by reflex action; hence also it is that uterine, stomach, and mental troubles aggravate acne. But there is something more than this to be said. In some persons, the sebaceous glands seem naturally to be specially active. The skins of these persons are greasy, the secretion of sebum is freer than in others, and it may be perhaps different in physical characters, and when additionally excited the glands may readily be blocked with sebum, so produce comedo. Now, it has always appeared to me that lymphatic and strumous subjects are prone to acne. At a time when the glands are physiologically active, the gland function is apt to be disturbed: they become congested, and the congestion may be excited, or, at least, it is intensified by local irritants, by reflected irritation from the stomach, or mental and uterine disease. In most cases, the secretion of sebum blocks the gland ducts, and the glands inflame as the result of the blocking up of the outlet, and perhaps the decomposition of the retained contents. These influences will, of course, only account for the plugging up of the glands and a certain amount of congestion of them. The intensity of the inflammation, or, at least, of its effects as shown by the amount of pus production, and the degree and exact character of the subsequent hyperplasia will depend upon the constitutional condition of the individual. In fairly vigorous subjects, the acne will be slight, and if all goes well, the inflammatory symptoms will subside without leaving any remnants of mischief behind. If the subjects in whom acne occurs are very dyspeptic, and if the dyspepsia, by its severity and long continuance (or if uterine mischief) cause much intensification of the hyperæmia, say of the face, and particularly if the patient be weak, the disease will be chronic, and the chronic inflammatory thickening about the glands marked. If the patient be strumous, there will be probably much implication of the connective tissue about the glands, free pus production, and the disease will probably leave behind it much pitting after the removal of the large, indolent, livid swelling that forms about the glands.

Hardy, after discussing the prevalent opinions concerning the etiology of acne, reaches the conclusion that all causes that induce congestion of the face exert a real influence on the development of the disease.

Guibout says: Whatever causes irritation of the skin may provoke an acne; thus, the use of cosmetics whether in the form of powder, soap, liniments, or ointments is frequently followed by the eruption of acne. It is frequently seen among actresses the necessities of whose occupation lead to an almost constant use of cosmetics, and also among ladies in private life whose vanity takes precedence of their good sense.

Beside local irritation Guibout recognizes chronic gastro-intestinal troubles as efficient causes of acne.

Hebra is undecided as to the causes of acne, but states that it frequently occurs in connection with disordered menstruation and disappears when this function again becomes normal. Kaposi cites chronic dyspepsia as among the predisposing causes of acne.

Profeta lays special stress on the sexual function in connection with the etiology of acne, and cites the observations of Frank and Rigler that the affection is exceedingly rare in eunuchs.

Gamberini notices amenorrhœa, dysmenorrhœa, and masturbation.

Duhring says: One of the most common causes of acne is to be found in habitual derangement of the alimentary canal. Experience with a large number of cases teaches this in most emphatic language. Disorders of the stomach and bowels, including dyspepsia and constipation, are to be considered as among the most frequent and potent causes of the disease. In some cases, even slight derangement of the bowels is sufficient to bring forth the lesions, which will be observed to become better or worse as the internal condition is improved or neglected.

Uterine disorders, particularly those of a functional character, are also to be viewed as the origin and direct cause of some cases of acne.

I conclude this series of citations by citing the views expressed by me some years ago, in which I declared a firm belief that in the great majority of instances acne is not a primary condition, but one dependent on irritation, derangement, or disease of other organs reflected on the skin: the special organs involved being those connected with the sexual and digestive systems.¹

A review of the foregoing leads us to four classes of assigned causes, to wit:

Local irritations.

Gastro-intestinal derangements.

Masturbation.

Uterine derangements.

These we will consider seriatim and endeavor to assign to each its proper relative importance.

Local Irritations.—Almost every dermatological writer, one following another, has assigned these among the causes of acne and has attributed to them, I think, a factitious importance. On the contrary, my own belief is that external causes have very little if anything to do with the production of this affection, and I base this opinion on several factors. First, in my own experience I have never yet found a case of acne in which I could, after the most diligent inquiry, ascertain that it was the

¹ Elementary Treatise on Diseases of the Skin, New York, 1876, p. 220.

result of any definite external and local irritation. Second, a very large proportion of our cases are met with in young men between the ages of seventeen and twenty years. Certainly these persons are not specially addicted to the use of cosmetics, of powders, liniments, or ointments applied for the purpose of beautifying an already sound and normal complexion. Here then we have at the very lowest calculation at least one-third of the cases excluded from this category. Third, if, as is asserted, acne is specially prevalent among actresses who, as a class, are undoubtedly given to the habitual and excessive use of cosmetics, can we not find other causes which notably tend to derange the health and the functions of the skin? Are the frequent exposure to draught in the theatre, to inclemencies of the weather in going and returning, the late suppers, and the liberal libations to be entirely overlooked in this connection? But further, are the cosmetics most in use composed of irritant substances? If in the form of powder, we find that the basis is, usually, starch to which is added perhaps a little chalk, bismuth, zinc, carbonate of lead, or talc, and if of a pinkish hue contains a very little carmine. If a fluid, the basis is water with a salt of lead or zinc, and a little benzoin. Now none of these substances can be placed in the class of irritants, and I have yet to meet with an ordinary cosmetic that contains arsenic, vermilion, or corrosive sublimate or other truly irritant substances except in the instance of a few freckle lotions that contain a small proportion of corrosive chloride of mercury. Fourth, if acne is producible by these local irritant agencies, why is it, I may ask, that physicians so commonly seek to remove the affection by the direct application of irritants? Why is it that almost every work on skin diseases recommends the use of such substances as green soap, sulphur, corrosive sublimate, biniodide of mercury, iodide of sulphur, etc., as being useful agencies in the treatment of the disease? That they are useful is beyond dispute, and the very fact gives us strong *a posteriori* reasons for disputing the assertions made concerning the etiology of the affection. Very curiously, those who specially hold to the local irritation theory are the ones who are the most zealous advocates of irritant local treatment. To them I leave the task of explaining the rationale of their methods.

Gastro-intestinal derangements.—We here find ourselves on much more solid ground. Few observant physicians doubt the fact that the condition of the stomach and digestive organs, including the liver, is capable of influencing the cutaneous circulation and more especially that of the face. Just how this influence is exerted we do not know, but we do know that after excesses, whether of food or drink, the face is apt to flush, and we can readily imagine that a meal which would be as nothing to man in sound health, may be a very burdensome excess to some poor dyspeptic. Now anything that tends to the production of poor blood, or to

a disturbance of the circulation, will lead to changes in the organs of least resistance: and organs of least resistance are usually those in process of development or in a state of unusual physiological activity, and this is the case with the sebaceous glands at the period in life when acne is most rife. Constipation is a not infrequent accompaniment of acne, and its relief is almost always followed by improvement in the eruption. These points, however, need not be dwelt on further than to say that my own experience accords very fully with that of Duhring as expressed above, to the effect that gastro-intestinal disturbances are a real and marked etiological factor in the disease under consideration.

Masturbation.—The idea that there is some connection between sexual derangements and the development of acne is by no means a novel one. More than a hundred years ago Plenck¹ alluded to the matter in the following words: “*Juvenibus victu crasso utentibus et spermaticis sunt familiares*” (*vari*). The exact sense in which Plenck used the word *spermaticus* is, I must confess, by no means clear to me. Hoping to ascertain its meaning in this connection, I turned to the German translation² of Plenck's works, published a year later. To my surprise, I found the sentence entirely omitted.³ Whatever may have been his precise meaning, it certainly points in the direction indicated, namely, a relation between acne and the spermatic function. Many writers since Plenck have attributed the development of acne to masturbation and seminal losses, while others, on the contrary, have been disposed to refer its production to continence, claiming that the affection usually disappeared after marriage. Whether either, both, or neither of these views are correct, is a question not easily settled. So far as my own experience goes, I have met with little or no evidence in support of the idea that the affection arises as a direct result of continence, that is, in the male sex. Much more frequently I have thoroughly satisfied myself that the reverse was the case. To ascertain the exact bearing of masturbation on acne would require minute inquiries in a large number of cases, and correct and truthful answers to them. In males this is comparatively an easy matter, but in females it is unquestionably very difficult to arrive at the truth. With young girls, direct questioning is hardly to be thought of, unless other signs point most unmistakably to the practice, and even then the facts are more easily arrived at by addressing the inquiries to some older person who may be in a position to learn something of the patient's habits.

So far as the disease occurs in young men, I have no hesitation in saying that the practice alluded to has, in very many instances, been the unquestionable cause of the trouble. In young females I have frequently

¹ Doctrina de Morbis Cutaneis. Vienna, 1776, p. 59.

² Lehrsätze von den Krankheiten der Haut. Warschau, 1777.

³ It is, however, found in the second Latin edition of still later date.

suspected it, but have rarely been able to positively verify the suspicion. In married women acne is by no means rare, and in cases where there is no evident uterine disease or derangement, nor any gastro-intestinal trouble, the chief etiological factor often eludes the most careful search. That imperfect sexual hygiene in married women is often at fault, I have no doubt, as in not a few instances a persistently relapsing acne has permanently yielded to treatment after normal habits were re-established. As evidence, a case in point may be cited. From a lady, thirty-two years old, married eight years, the following history was elicited :

An acne of the cheeks and temples had existed one year ; previous to that her complexion was without blemish, her general health, strength, and spirits were excellent, her menstrual periods were normal as regards time, quantity, and quality, no pain, no leucorrhœa ; appetite and digestion normal, and bowels regular. In reply to her question, "What does the eruption come from?" I was obliged to state that I did not know; and that until I did know, could give her no opinion as to prognosis. She then volunteered the statement that she was troubled with "nocturnal emissions," and in connection with the matter stated that, during the first seven years of her married life her husband's business kept him from home the greater part of the time, his visits to his wife being at long intervals, and but for two or three days at a time. During the past year, however, he had lived with her constantly, and intercourse took place once or twice a week. On these occasions the husband habitually finished before the orgasm occurred in the wife. Left in an unsatisfied condition, she passed a restless and uncomfortable night, and often before morning had an orgasm and an "emission." After these occasions, she would have an eruption of "pimples." This appeared to give a clue to the cause of the acne. A few days later I had a frank conversation with the lady's husband, who promised to manage matters better in the future. The case was left without medical treatment, and a few months later the patient called and stated that she was perfectly satisfied with the result, both as to her complexion and otherwise.¹

The case is related to show that, however obscure the etiology of a case of acne may be, it may sometimes be ascertained by diligent inquiry, or, as in this case, be unexpectedly revealed. I have no hesitation, therefore, in classing masturbation, and what may be termed defective sexual hygiene, as among the causes of acne, both in youths of either sex, and those more fully matured.

¹ Involuntary nocturnal orgasm in women is a subject that, so far as I am aware, has been left unnoticed in medical literature, but is without doubt of more frequent occurrence than is generally supposed. Prof. T. G. Thomas has recently informed me that he can recall quite a number of cases, usually in those who had been masturbators.

Uterine Derangements.—Under this head I include both functional and organic anomalies of the most varied sorts. Not being a gynecologist, I do not pretend to arrange the morbid symptoms and lesions in proper nosological order, and can only note the fact that in a very large proportion of cases of acne in both young and somewhat older women, uterine derangement of some sort has been present, as evidenced by amenorrhœa, delayed or scanty menstruation, dysmenorrhœa, menorrhagia, etc. In many the cutaneous lesions are decidedly aggravated at or about the menstrual period, and when these various conditions have been relieved, the acne yields to treatment that had previously been ineffectual. This, it seems to me, is sufficient evidence of the etiological dependence of the cutaneous lesions on the internal trouble.

So much for the remote causes of acne. The proximate causes, or early local changes that occur in acne, are far from being satisfactorily explained. It is supposed by some that the excessive formation of sebum or its retention within the follicles (*comedones*) excite an inflammation of the follicular walls and peri-follicular tissue, resulting in the formation of papules and pustules. Others (Denslow) think that the peri-follicular unstriped muscular fibres lose their tone, and thus delay the extrusion of the sebum. The fact is, very little is known about the matter, hardly more than was known to Daniel Turner, the first English dermatologist, who, in 1714, wrote concerning the causes of acne, adopting the views of Florent, a still earlier writer, who “deduceth the cause from a hot, but viscous and thick blood generated by some intemperance or vice of the liver, which being brought by the capillary arteries to the surface of the skin of the face, is there diffused as happens in blushing, but by reason of its leantour or clamminess, not being returned as it aught presently by the veins, stops therein and causeth redness, which neither yet being capable to be disencst by reason of the density of the cuticle, raiseth the same up into little pustules, and at length ulcerates, having vitiated the frame of the cutaneous glandules by its long stagnation.”

ZONA OF AN UPPER EXTREMITY.

1. ZONA of an upper extremity has of late been more frequently observed since greater attention has been paid to trophic lesions consequent upon cerebro-spinal disorders.

2. The eruption extends towards the forearm in a longitudinal direction, which is always the same on the inner and outer portions of the limb.

3. Clinical observation of this variety of zona has furnished additional evidence in favor of the nervous origin of the disease.—STOPIN (*Th. de Paris*, 1882).

¹ A Treatise on Diseases incidental to the Skin, by Daniel Turner. London, 1714.

Correspondence.

DERMATOLOGY AND SYPHILOGRAPHY IN FRANCE.

(From our special correspondent.)

ALMOST simultaneously with the appearance in the *Philadelphia Medical News* of an article on the TREATMENT OF LUPUS by Dr. G. H. Fox, one of the most distinguished dermatologists in America, Dr. P. Aubert publishes (*Annales de Derm. et Syph.*, May 25, 1883) a very interesting article on the same subject. In this he carefully details the methods at present employed in France, and at Lyons in particular, and shows that the distinctive peculiarity of the present tendencies in the treatment of lupus is the abandonment of the old procedures, consisting in potential cauterizations with chloride of gold, nitrate of silver, potassa, chloride of zinc, etc. In practice these have proved too painful, too slow in action, leaving deforming cicatrices, and too often followed by failure.

The new methods act better and more rapidly, but they have the great inconvenience of being painful, since they are exclusively surgical. In America, where it is the practice to enucleate the tubercles with the curette and immediately cauterize each small excavation, completing the treatment in one or two operations, general anæsthesia and the protoxide of nitrogen is employed; in Paris, lupus is ordinarily treated by quadrillated linear scarifications, and since the séances are daily, local anæsthesia by atomization of ether is practised only when patients are timid. The patient soon learns to support this operation without an anæsthetic, which is, of course, much preferable, as the extent of the disease can be much better perceived than when the tissues are frozen—the softness of the tubercles contrasting with the firmness of the surrounding healthy parts. M. Aubert informs us that at Lyons the physicians do not hesitate to etherize their patients, which enables them to accomplish much more in one sitting, and thus more quickly complete the cure. For this purpose they give the patient, fifteen to thirty minutes before the anæsthetic, a subcutaneous injection of 1 grain to 1.50 grain of the following solution: chlorohydrate of morphia, 10 centigr.; neutral sulphate of atropine, 5 milligr.; aq. destillat., 10 grs. This is followed by the inhalation of ether.

M. Aubert believes that the extirpation of the lupus with the bistoury is a bad method, for the lupus redevelops in the cicatrix even if the precaution has been taken to remove it freely. He thinks that racleage gives quite good results, provided that it be energetically practised, and that the scraping be continued as long as a particle of tissue comes away, for the embryonic elements are readily detached, while the sound tissues resist. During the process of cicatrization, it is necessary to modify the fresh surfaces with dressings of iodoform, ten-per-cent ointment of pyrogallie acid, carbolyzed ointments, nitrate of silver, etc. According to Aubert, racleage is especially useful in papillomatous and erythematous lupus, where scarification alone is not efficacious; in these cases, he even combines scraping and scarification. The Lyonnaise author insists strongly upon the employment of the hot iron in the treatment of lupus. It is a practice very much in vogue in Lyons, but which has been altogether abandoned in Paris. It is necessary to cauterize deeply so as to destroy the entire patch of lupus and also

the zone which surrounds it, which renders this method inapplicable when the disease involves large surfaces; but where it can be employed it gives, in a single sitting, good cicatrices, and is not apt to be followed by a recurrence. This method appears most excellent when the lupus is situated upon covered portions of the body, but it is preferable to treat lupus of the face by quadrillated linear scarifications, which cause less loss of tissue, and give smooth, supple cicatrices, without the slightest contraction. They are practised with the two-edged cutting instrument of Vidal, which is held as a pen, delicately, without rigidity, and without pressing it between the fingers. The incisions must be made perpendicularly to the surface of the skin, and should penetrate to the farthest limit of the diseased tissue, that is, until the peculiar resistance characteristic of healthy tissue is felt. With the fine point of the instrument it is easy to search out the neoplastic tissue in its entire extent.

Parallel incisions, as closely approximated as possible, are first made; these are immediately crossed by oblique incisions forming a hatch. When this scarification is found insufficient, other incisions may be made, again crossing the former ones obliquely, so as to have a hatched surface, thoroughly delacerated, and extending to the bottom of the lupus infiltration. It is even necessary to go a little beyond the limits of the disease, especially towards the borders of the patch. At the end of five or six days, we have a red surface upon which we can scarcely see traces of the incisions. A new scarification is then practised, and so on to the end. In the interval of the sittings, it is well to have the diseased surfaces covered with the emplastrum de Vigo, in order that they do not become too much inflamed. Such is the method, described concisely as possible, which is followed by M. Vidal, of the Hospital St. Louis, of Paris. By this method, which demands, it is true, much patience on the part of both patient and operator, many cases of lupus of the face may be cured without deformity, and one may even say without cicatrix. M. Vidal has always been able to arrest in two or three sittings the advancing and profoundly destructive progress of lupus vorax.

The thèse of M. Chaussat (Paris, 1883) upon the TREATMENT OF CALLOUS ULCERS by radiate scarifications shows us still another application of surgery in the treatment of cutaneous diseases which has been so prominently brought forward by M. Vidal.

First directing the patient to remain in bed a few days, and subduing any inflammation which may be present by poultices, this surgeon makes linear scarifications along the borders of the ulcer, only slightly penetrating the ulcerated parts, but extending into the healthy tissues two or three centimetres, according to the degree of induration and the elevation of the edges. They involve the derma, but never so deeply as to penetrate the superficial aponeurosis. The loss of blood attending this little operation is quite insignificant; it is arrested by the application of a little wadding which, after two or three hours, is replaced by poultices. In the course of two days, the slight inflammation which followed the scarifications has generally disappeared, and the ulcer is then dressed with powdered subcarbonate of iron. This method is especially applicable in the case of old ulcers with hard, callous, elevated edges and depressed centre; the vitality of the integument is modified and the callosities disappear much more promptly.

M. Corneau has (*Th. de Paris*, 1882) considered the treatment of WARTS involving the soles of the feet. He has called attention to the fact that while these small excrescences possess no gravity, *per se*, yet they are none the less the frequent

cause of excessive pain which may result in a complete incapacity for work, and that it is necessary to intervene in a majority of these cases.

The greater number of surgeons make abrasions with the bistoury, and immediately cauterize either with chromic acid or with arsenical paste, chloride of zinc, butter of antimony, nitrate of silver, etc. Prof. Verneuil practices the ablation of the tumor with the bistoury; the cure is rapid, usually effected within the course of ten days. M. Dupres places upon the tumor a piece of Vienna paste the size of a pea, leaving it in position one-half hour. He then dresses the eschar with diachylon. Usually a single cauterization is sufficient to destroy the morbid growth, and the patient can walk at the end of a fortnight.

Prof. Guyon is accustomed to abrade the epidermic cuirass, and then cauterize with glacial acetic acid. This last method is somewhat slow, for it is necessary to repeat the sittings quite often, but it has the advantage of being almost painless, and gives excellent results.

Since the first investigations of Prof. Fournier into the relations between SYPHILIS and LOCOMOTOR ATAXIA, physicians have been divided into two camps, the one admitting, the other rejecting syphilitic ataxia. The researches of Dr. J. C. Wilson (1879), of Erb (1880-81), of Gowers, of Althaus, etc. (1881), of Savard (*Thèse de Paris*, 1881), of Dreyfus-Brisac (*Gaz. Hebdomadaire*, No. 39, 1881), of Cayla (*Thèse de Bordeaux*, March 21, 1882), have received a certain sort of consecration in the magistral work of M. Fournier upon "Locomotor Ataxia of Syphilitic Origin" (Paris, 1882), in which the learned Professor boldly affirms *that in the enormous majority of cases locomotor ataxia constitutes a manifestation of syphilitic origin and nature*. But all French physicians are by no means convinced, the incredulous, we believe, are in a large majority, so that, while the illustrious master has already taken pains in his work to refute in advance the various objections which might be brought against his theory, they have begun in our country to make a breach in his doctrines. M. Abadie, one of our most distinguished ophthalmologists, has just declared to the Society of Medicine of Paris that in his opinion the question of locomotor ataxia has been befogged instead of being cleared up. He asserts that the forms designated as "masked" or "irregular" have become so numerous that the principal disease has disappeared.

M. Abadie cannot refrain from raising the objection to the partisans of a syphilitic ataxia that the disease has been especially observed in cases of syphilis which have been neglected, and which have passed through their evolution without notable secondary accidents, but every individual who has had only a chancre without any ulterior accident, should not be regarded as a syphilitic. This author remarks, moreover, that, according to M. Lancereaux (*Leçons sur la syphilis cérébrale.—Gaz. Hebdom.*, 1882), syphilis is by no means systematic in its lesions, and besides that ataxia is not ameliorated by antisymphilitic treatment. He then considers the question more especially from an ophthalmological standpoint, and shows that in optic atrophy depending or not upon locomotor ataxia, occurring in individuals who have had a chancre, that mercurial preparations are injurious rather than useful, while in cases of true syphilitic optic neuritis there is always an amelioration from mercurial frictions. In atrophy of the optic nerves observed among ataxics or where ataxia does not exist, the process is never inflammatory, and the changes, which occur slowly, reveal themselves by a simple discoloration and not by redness, ulceration, or infiltration, as do all undoubted syphilitic manifestations. In the beginning of ataxia, systematic lesions already exist, and however slightly pronounced they may be, their atrophic character is already quite distinctive; there is neither congestion nor infiltration nor exudation as in

the morbid products of syphilis. Such facts are, in the opinion of M. Abadie, decisive arguments in favor of the non-specificity of *tabes dorsalis*.

At the following meeting, Dr. Duboc, having reported a case of *tabes dorsalis* which was, in his opinion, undoubtedly of syphilitic origin, M. Abadie rejoined and showed that, according to Savart, while syphilitic medullary lesions are numerous and varied, they are always transverse rather than longitudinal. They may have presented at a given time some symptoms of true ataxia, but this is no reason for confounding them with the latter affections. Besides it is incontestable that a syphilitic may be ataxic.

All these arguments have been again revived by M. De Ranse and presented in an important memoir which has just appeared in the *Gazette médicale de Paris* (April, 1883). He states the questions as follows:

1. May syphilis cause a primary ataxia, *d'emblée*, in the same manner as it produces a gumma or a syphiloma?

2. May it give place to a secondary ataxia, presenting in its evolution the classic type?

3. May it produce only simple tabetic phenomena due to an accidental lesion and limited to the external ribbons of the posterior columns?

If there be a true syphilitic ataxia, it is clear that this term is applicable only to a primary ataxia. Of the lesions of the cord undoubtedly syphilitic, some are *diffuse* (diffuse medullary sclerosis, meningitis), others *circumscribed* (gumma, nodules, syphiloma of the meninges or of the cord). They almost always accompany multiple lesions, either of the nervous centres or of other parts of the organism, and leaving no doubt of their specific nature: they may attack in certain cases the external ribbons of the posterior columns, and patients may then present symptoms of *tabes*, as has already been remarked by Dr. Abadie, and it must be admitted that the morbid process may, under the influence of a particular predisposition, then extend along the posterior fasciculi. But in these cases the primitive syphilitic lesion has only been the accidental cause of the sclerous process which remains either a localized myelitis or an ordinary locomotor ataxia.

Never, on the contrary, does fascicular sclerosis of the posterior columns figure by the number of its primary and essential lesions which an autopsy reveals as being of a purely specific nature; and, on the other hand, it is quite rare to find in the autopsies of true locomotor ataxia specific lesions associated with fascicular sclerosis of the external ribbons. This sort of exclusion of the two classes of lesions of pure syphilis and pure ataxia in their relations to each other, constitutes, in the opinion of M. de Ranse, a presumption against the specificity of *tabes*. He even goes farther, and discusses the value of the statistics upon which M. Fournier has relied to establish his theory, and he demands why locomotor ataxia is not more frequent among syphilitics if it is almost always of a specific nature.

As to the question of treatment, M. de Ranse does not believe that we are justified in concluding that a syphilitic locomotor ataxia has been cured when we have caused certain accidental tabetic phenomena to disappear by the administration of mercury and iodide of potassium: for, first, the tabetic phenomena may not pertain to a true locomotor ataxia, but to an accidental propagation of specific medullary lesions to the external ribbons of the posterior columns; and second, mercury and iodide of potassium may act very well in cases notoriously exempt from syphilis. In the opinion M. de Ranse, the efficacy of these medicines in locomotor ataxia is no greater when there are syphilitic antecedents than when there are none, while in the majority of cases of cerebral syphilis there is a

prompt amelioration and cure by specific treatment; it is then, he says, quite astonishing, if locomotor ataxia be a direct and primary manifestation of syphilis, that specific treatment should be without action upon it. The inefficacy of the treatment argues in favor of the non-specificity of the lesion.

Besides, he adds, antisyphilitic treatment is incontestably useful and efficacious in cases of tabetic phenomena, symptomatic of cerebro-spinal syphilis, and, perhaps, also at the début of a secondary ataxia developed under the same conditions, while it is not only useless, but oftentimes even harmful, in primary locomotor ataxia; it should not, then, be prescribed in an absolute manner and indifferently in all cases with tabetic symptoms.

Professor Fournier, as we have before said, has in his book already refuted, with his admirable logic, the most of the arguments just alluded to. We will not stop to reproduce them here, but we may be permitted, nevertheless, to recall the brilliant argumentation with which the distinguished master has combated two of the strongest arguments of his opponents:

1. *Syphilis should not determine tabes, because it is not the nature of syphilis to produce systematic lesions.*—To this, M. Fournier responds that it is only a theoretical consideration, which should not prevail against the undeniable facts furnished by clinical statistics, that syphilis may systematize itself and affect exclusively the bony system, the hairy system, etc., and why not also the columns of the cord; that finally ataxia, far from being always exclusively systematized in the external ribbons of the posterior columns, may, instead, present anatomical lesions much more diffuse, attacking either the meninges or other parts of the cord.

2. *The tabes which occurs among syphilitics is not of a syphilitic nature, for it experiences no benefit from syphilitic treatment.*—Yes, certainly, responds M. Fournier; treatment has no effect when instituted late, when the posterior columns are already altered and destroyed, for antisyphilitic treatment has not the virtue to reproduce them any more than it has the virtue to fill up a palatine perforation of specific origin. But, on the other hand, it is certain that specific treatment often exercises a curative influence upon the symptoms, and upon the evolution of specific tabes. We ourselves have been fortunate enough to have observed these ameliorations in certain cases; in one, especially, the arrest of the progress of the ataxic accidents was so clear and distinct, that we will cite it in closing. It was the case of a friend, aged 39 years, who had had an indurated chancre in 1867, followed by some fugacious secondary accidents. He had never been treated. About 1876 he experienced the first fulgurating pains, and in 1881 he was so ataxic that he could not make a step without being supported. In July, 1881, we placed him upon a vigorous mixed treatment (4 grms. of Neapolitan ointment in frictions, and from 4 to 8 grms. of iodide of potassium per day; leeches and hot irons to the vertebral column), during one month. After that, we made him take alternately tonics (syr. of iodide of iron, cod-liver oil, etc.), and iodide of potassium. We also continued the employment of revulsives. His condition was so improved during the year, that he could take long walks alone, and since the month of August, 1882, his condition remains stationary, without the least aggravation.

BROCQ.

PARIS.

ATLANTA, GA., July 19, 1883.

Editors Journal Cutaneous and Venereal Diseases.

GENTLEMEN:—I had occasion to use the remedy recommended by Shoemaker, of Philadelphia, for the removal of freckles, quoted in your April number, upon

two patients, and each time about a week after the beginning of treatment, was rewarded by a beautiful crop of furunculosis, but the freckles were not at all influenced by its use. The remedy was prepared agreeable to the formula by him laid down, but the above have been my results.

Have you had any such experience? Yours, etc.,

L. E. BORCHEIM.

Selections.

WHAT IS THE BEST TREATMENT OF ECZEMA AND OF PEMPHIGUS?

THE term *eczema*, in the first place, is utterly unscientific, carrying with it no indication which is not more aptly expressed by the generic title *dermatitis*, with its many therapeutic suggestions and associations. Under this name, we may, with simple clinical truth, delineate four grades of inflammatory action, which may be characterized as follows :

(A) The powdery desquamation of chronic passive erythema, or so-called *pityriasis*; (b) the active papillary hyperæmia, with enormous exfoliation, which constitutes *pityriasis rubra*; (c) the serous exudative inflammation which is called *eczema rubrum*; (d) the purulent exudative inflammation which has been known under the names of *impetigo* or *porrigo*. These conditions, being bound together by an obvious pathological link, should be spoken of as dry and moist forms of inflammatory action. Essentially, the process is the same in all of them, but underlying all their phenomena, there must be a special vulnerability of skin, or readiness of the skin to be irritated.

As to their therapeutics, the point to be aimed at in the treatment of red weeping dermatitis (*eczema rubrum*) is the application of something which is not a powder and not an ointment, but combines the virtues of both with the drawbacks of neither. This aim is fulfilled by a soothing fluid which holds an astringent powder in suspension, and equally diffused through it. Take half an ounce of oxide of zinc, four scruples of the best calamine, a fluid ounce of glycerin, and seven ounces of lime-water. Add a little lime-water to the dry powders, and mix into a paste; pour in more lime-water, and stir in a mortar until the ingredients are well mixed. Then put the whole into a bottle, and add the glycerin last. Before using, shake the bottle well, and pour a little of its contents into a shallow, open vessel, as a saucer. Take strips of lint or linen rag, from two to three inches wide, and of different lengths, to correspond to the different diameters of the limb. Soak them in the lotion, taking up on their surface as much of the powder as possible. Carefully adjust these medicated strips over the affected part of the limb, and then around all wind evenly, and with gentle pressure, a bandage made from a calico of open texture, like what is used by farmers as a covering for cheese. This process must be repeated at first every morning and evening, taking care that the strips are well moistened with warm water before removal, although the glycerin in the lotion prevents them from ever becoming quite dry. Commonly, this plan succeeds very well; the skin gets softer and less moist; soon only one dressing in the day is required, and, in cases uncomplicated with visceral disease, a cure is speedily effected.

In some cases, when all local symptoms have subsided, a place will be found for a combination of lead and zinc ointments, or a mixture of acetate of lead and oxide of zinc with cerate of petroleum, which soon produces a dry, soft, glossy skin.

Dry patches of chronic dermatitis, clearly eczematous in origin, are curable by the application of tar. But the tar must be weakened down by being mixed with astringent and soothing mineral powders. This is an essential qualification for the benign use of tar in any form of skin disease; and it is because this precaution has been often neglected, that the external application of tar has been passed over and even disparaged. Of all the emollient materials proper to be mixed with tar, chalk is *facile princeps*. Finely-levigated chalk should be strewed into melted lard in a stone jar, and thoroughly stirred until cold. Now, if the merest morsel of *ung. picis liquide* be added to chalk ointment, just sufficient to yield a brown smear of color (and the eye is the best judge in such a matter), the infiltration and scaliness of an old dry dermatitis will gradually soften down; and, if assisted by the right auxiliary means internally, there will be nothing left in the long run but a pigmentary stain. In many cases, the addition of a small percentage of *unguentum hydrargyri nitratis*, or of a few grains of the nitric oxide of mercury, is a material help.

Pemphigus should be regarded as an essentially neurotic disease. It cannot be cured, or even any substantial progress made toward a cure, without the use of arsenic. In the case of a young gentlemen who had suffered greatly from this complaint on his hands for seven years before its true nature was suspected, the treatment which proved effective was of the simplest kind. At first I applied to the fingers a combination of vaseline and lead ointment, adding subsequently a small proportion of *ung. hydr. nitratis dilutum*. But local remedies soon became unnecessary. Iron and arsenic were administered internally from the beginning, and with the best effect. Now and then these medicines caused an inconvenient alvine looseness, but from October, 1882, to January, 1883, they were taken daily with such regularity that if all the omissions were counted up, they would not measure in time more than eight weeks.

The history of this case illustrates one of the professional and popular fallacies about skin diseases. They are not to be "driven in," or, in other words, they are not to be cured lest worse internal troubles should follow. How many babies have been made miserable by this fanaticism, and been doomed to suffer a running dermatitis of the head or even of the whole body, until the last stage of malnutrition has been reached, and death has nearly closed the scene! Hebra laughs heartily at this grandmotherly scheme of physiological pathology. Do we ever say that we must not try and cure an old muco-purulent bronchitis lest the *sputa* be driven inwards?

There is a great divergence of medical opinion on the relative degree of the constitutional and local causes of dermatitis. Sir Erasmus Wilson seems to hit the middle path when (in the preface to his *Diseases of the Skin*, fifth edition, 1863), he speaks of the necessity of "combining the neuropathist and the humoropathist," he contends for the importance of recognizing the "constitutional origin of local disease," and the "delicate handling of a local disorder." Of the two errors, that of wrongly "handling" the outward and visible disease is by far the greater. But experience confirms the practice of those dermatologists who think that the action of the kidneys ought to have special medical attention. It is certain that scanty urine and constipated bowels may baffle the most skilful local means.—JOHN KENT SPENDER; *Practitioner*, June, 1883.

LOCAL TREATMENT OF ACNE SIMPLEX AND ACNE ROSACEA.

THIS can be satisfactorily carried out only by direct action upon the malady at its original seat. The following is the method devised and recommended by the author :

He takes a fine darning-needle, having an eye somewhat longer than that of a sewing needle. Holding this by the point, he introduces it into the affected gland by a rotary movement which causes some of the sebaceous matter to lodge within the eye of the instrument. The latter is withdrawn, cleansed, and re-introduced, and the operation is repeated once or twice until the gland being emptied, its floor is touched by the needle, when a slight pricking sensation is experienced. The same needle, or another similar one, held in the same way, is then dipped in an alcoholic solution of iodine—of greater or less strength, but never weaker than that of the French pharmacopœia—and is again passed into the gland, charged with a drop of the iodine tincture, which is thus brought into immediate contact with the focus of the disease. After a few minutes, a clear liquid, slightly colored by the iodine, will exude from the gland, sometimes in a drop as large as a tear. This flow will cease within an hour. Twenty-four hours later, in cases of acne simplex, the inflammation, when unaccompanied by suppuration, will have wholly disappeared. If suppuration, however, had existed, it will be found perceptibly diminished, needing only two or three repetitions of the process to effect its entire cessation, followed by a permanent cure.

Acne rosacea, being of a more intractable character, requires the application to be made several times, when results equally favorable will certainly be obtained.

The advantages claimed for this mode of treatment over any local measures previously employed, are: That it is easily carried out : produces no additional disfigurement: is painless; does not necessitate the seclusion of the patient, and may be relied upon to effect speedy cures even in cases otherwise hopeless.—MORIN (*Th. de Paris*).

A CASE OF GENERAL SARCOMA CURED BY SUBCUTANEOUS INJECTIONS OF ARSENIC.

THE patient was a girl eight and a half years old, of slender build and feeble constitution, but, so far as could be ascertained, of good family history. When first seen by the author, July 9, 1881, her condition was as follows: On the face, especially the cheeks, were numerous prominent tubercles, as large as half a pea, of a brownish-red color, changing to grayish-yellow on pressure. A few of these were covered by small, firmly adherent scabs. The tubercles were exceedingly hard, and this hardness could be felt to a considerable extent both around and beneath them. They were not painful on pressure. A similarly firm and painless growth, larger than a pea, was seated on the right ala nasi; it was of an almost jelly-like translucency, and its surface was covered by a delicate vascular network. The breasts, abdomen, and back were smooth. The upper and lower extremities displayed a great number of medium-sized excrescences, essentially like those on the cheeks, but of a bright reddish color. Among these, however, were some which were much smaller, angular in outline, slightly depressed on the surface, and varying in color from dull yellow to reddish. The palms of the hands were free from growths, and the soles of the feet presented only a few slightly prominent tubercles. A gland in the right elbow was swollen, and there was enlargement of the lymphatic follicles in the pharynx, with moderate anemia of the mucous membrane. The abnormal formations had *first* been

noticed on the right cheek and left ala nasi in April, 1881, *simultaneously with those on the extremities*.

A single vial of Fowler's solution of arsenic, three drops twice a day, beginning May 26, was all the medicine that had so far been taken.

The diagnosis, in the light of two fatal cases of general sarcoma previously treated by the author (and described in *Arch. f. Derm. und Syph.*, p. 373), was determined at once, but owing to the patient's absence on a journey, treatment was not commenced until September 12th. During this interval the development of the neoplasms advanced enormously, especially on the cheeks and extremities. Isolated growths also made their appearance on the chest and scapular region. The tubercle on the nose, in particular, was now as large as a bean, extremely hard, and almost of a purple color, with its vascular network much more deeply injected. The liver and spleen were somewhat enlarged. The appetite was poor, and the general nourishment had declined since the first examination.

Although the progress of the case thus far had tended to fully confirm the diagnosis, it was resolved to subject the latter to a decisive anatomical test. Accordingly, two of the growths, as large as a lentil and a pea respectively, were removed from the patient's arm by a single oval-shaped incision. Microscopic examination showed them to be unmistakable products of a genuine *spinulocelled sarcoma of the skin and subcutaneous tissue*.

Treatment was conducted as follows: From September 12 to December 9, Fowler's solution, one part to two parts distilled water (*the solution must always be freshly prepared for subcutaneous use*), was injected in doses of from one-third to one-half of a Pravaz syringeful containing 86 grm.; so that at each injection from two and a half to four drops, and in the whole three months 8 grm. of pure Fowler's solution were employed.

At the end of this period, the patient's condition, on the whole, was very slightly altered, although several small tubercles on the face and legs had begun to show a central depression, with the formation of fine, firmly adherent scales, or dry scabs. The scar left on the arm by the incision above spoken of was also now *somewhat elevated, hard, and sprinkled with very small tubercles*.

Consequently, from December 10 to January 17, 1882, equal parts of Fowler's solution and distilled water were prescribed, and the quantity injected at a dose was increased to six to nine drops. Altogether, up to January 5th (when the full effect was reached), 12.0 of Fowler's solution were injected, besides which, from November 12 to December 16, 30 grm. ferr. dialysat. solut. (eight and a half drops twice daily), were administered internally.

By January 5, a progressive amelioration in all respects had become strikingly apparent. The closely-set tubercles on the cheeks, especially, were completely sunken, and even those on the nose, including that which was formerly the largest of all, were considerably reduced, and much less livid in hue. The glandular swellings were also greatly lessened.

From January 5 to January 17, 2.75 of Fowler's solution were injected, making, since the beginning of the treatment, 14.75 grm., of which 6.45 grm. were injected at twenty-five sittings, during the five weeks since December 10.

January 15, only flat, reddish-brown, scar-like, somewhat depressed spots were visible on the forehead, temples and cheeks, and a corresponding change had taken place on all the other affected regions.

The total number of these then-remaining vestiges of the disease is set down by the author as about 310, distributed as follows: face, 56; ears, 10; body, 8; upper extremities, 4; lower extremities (excluding 11 on the nates), 201.

January 31, 1882, treatment was resumed, and at twenty sittings, up to March 25, 6 grm. liq. kali arsenicos. were injected, so that not more than 20.75 grm. of the latter (8.23 grm. of pure arsenious acid) were employed to effect the cure.

By November, 1882, the little patient had gained 53 pounds in weight. Her complexion was rosy, and the mucous membranes had lost their anemic appearance. Her skin everywhere was soft and smooth, excepting a few isolated tubercles of lichen pilaris on the arms and legs. Most of the scars had disappeared, and those that remained were greatly faded. Of the once formidable growth on the right ala nasi, not a trace was left.

This happy result had been maintained, under the author's constant observation, up to the date of his report, in January of the present year.—HEINRICH KÖBNER (*Berl. Klin. Wochenschr.*, 1883, No. 2).

LOCALIZED BLENNORRHAGIA IN THE FEMALE.

1. BLENNORRHAGIA in the female has a marked tendency to localization in certain well-determined points of the vulva or the vagina, either primarily, or when the inflammatory process has somewhat diminished.

2. Generally, blennorrhagia localizes itself in the glands of the genital apparatus.

3. Blennorrhagia may localize itself exclusively in the vulva. This constitutes *blennorrhagic vulvitis*.

4. But it may offer more intimate localizations and secrete itself within the glands of Bartholin, in the *peri-urethral follicles*, or in the *disseminate glands*, at the level of the labia minora of the fourchette.

5. *Blennorrhagic Bartholinitis* is quite frequent. It may present the following forms:

The acute form, terminating by resolution or induration, rarely by suppuration.

The subacute form, suppurating invariably, the blennorrhagic Bartholinitis then becoming complicated with a phlegmonous peri-Bartholinitis. The periglandular pus is not blennorrhagic, while the intra-glandular pus presents all the characters of blennorrhagic pus.

The chronic form. If the inflammation occupies the body of the gland, then there are chances of complications of peri-Bartholinitis and of contagion; while, if the inflammation be localized at the excretory duct, the chances are at the minimum. But the inflammation has a natural tendency to invade the body of the gland.

6. The peri-urethral folliculitis may be,

Simple. It then presents well-defined clinical symptoms.

Hypertrophic. It then becomes the point of departure of urethral polypi.

Suppurating. In this last condition, the disease is contagious. The contagion is effected by the introduction of a drop of blennorrhagic pus into the canal of the urethra, one of these follicular abscesses being broken during the act of coition.

7. Blennorrhagia rarely localizes itself in the glands of the labia minora or in the form of a patch in one or several vulvar glands situated at the level of the fourchette.

8. All the points of the localization of blennorrhagia may become exulcerated under the influence of inflammation, and thus become a point of entry for the chancreous or syphilitic virus.

9. Blennorrhagia may localize itself, when it occupies the vagina, in the cul-de-

sac, in the folds which are observed on the mucous surface, in the uterine neck, or even in the cavity of the uterus itself. In the latter two cases, it is frequently complicated with peri-uterine accidents, by the intermediary of a lymphangitis or of a juxta-uterine adenitis (adeno-lymphitis), which especially lead to adeno-pelvi-peritonitis.

10. It is rare that blennorrhagia localizes itself in the rectum; nevertheless, this fact has been observed, especially in the female.

11. It is important to recognize localized blennorrhagia in the female, and to not confound it with dermatoses, such as herpes or zona. Blennorrhagic Bartholinitis should be differentiated from traumatic Bartholinitis and cysts of the vulvo-vaginal glands.

Likewise it is important to distinguish peri-urethral folliculitis from inflammatory vegetations, and blennorrhagic vulvitis from simple vulvitis. Physicians ought also to be able to refer a blennorrhagic metritis to its true cause.

12. The prognosis should embrace two factors :

a. The patient is, by the fact of her localized blennorrhagia, subject to acute recurrences of a severe character.

b. She may become contagious, if any circumstance whatever should re-awaken the chronic inflammation and induce the least possible puriform or purulent condition.

13. In order to radically cure the disease, it is necessary, after the subsidence of the acute symptoms, to modify the inflamed points by energetic cauterizations, to even incise the gland of Bartholini and induce suppuration, if it should be the seat of localization of the blennorrhagia.—BOUTIN (*Th. de Paris*, Jan. 30, 1883).

THE ETIOLOGY OF PELLAGRA.

1. SEX and age are influential in the development of pellagra only by reason of the accidental conditions to which they subject individuals; men are more exposed than women to the predisposing causes of the disease, while infancy and old age confer comparative immunity.

2. Peculiarities of temperament and constitution, previous diseases, overwork, moral affections, alcoholism, insanity, cretinism, act in this direction merely by weakening the organism in their respective degrees.

3. Occupations, considered by themselves, exert but little influence; the disease is chiefly met with among agricultural laborers, because these are more liable than any other class to its predisposing causes.

4. Pellagra displays a decided preference for certain districts of Europe (Northern Italy, The Landes, Spain), which cannot be accounted for by any conditions of soil, climate, or locality that are there encountered.

5. Insolation is not an exclusive cause, either of the disease itself or of the accompanying erythema, and its effects, besides being secondary and confined to the skin affection, or to an aggravation of other symptoms, have been traced in a few special instances only.

6. An insufficient diet of Indian corn alone is one of the most efficient factors in the production of pellagra, but simply because such a diet tends, more than any other cause, to bring on organic decay and physiological impoverishment. When the cereal undergoes degeneration, either through the ravages of insects or from excess of moisture, these evil effects are intensified, but still do not suffice to solve the etiological problem.

7. A condition of extreme poverty, in which all the above elements are com-

bined, is what must be placed first among the predisposing causes, as preparing the system for the reception of morbid influences in general, and of those which give rise to pellagra in particular.

8. Hereditary descent must, by itself, be regarded as a direct cause of the disease, in certain comparatively rare cases.—CAVALCANTI (*Th. de Paris*, 1882).

HEBRA'S PRURIGO.

THE affection described by Hebra under the name of chronic prurigo, considered simply as a clinical entity, and without reference to any theory of its etiology, deserves to be distinguished from other forms of prurigo which have been denominated by French authors prurigo senilis, prurigo localis, etc.

Its occurrence at the earliest period of life, its resistance to therapeutic agents, its intermittent course, the successive crops it presents of strongly-marked papuloid eruptions, exhibiting, on the whole, a special morbid type—all these are characteristics sufficiently distinct to justify and even to compel the separation.

The disorder, in France at least, is comparatively rare. Its development commences almost with the infancy of the patient.

Its progress is marked by periods of alternate exacerbation and remission, with intervals of apparently perfect relief, whose duration seems to depend on the influence of the seasons and of temperature, also on accidental hygienic and psychical conditions.

The eruption leaves behind it traces, in the form of pigment stains, always clearly and regularly defined, always occupying a somewhat larger area than their preceding papules, and often of service in settling the retrospective diagnosis of this unfamiliar affection.

Treatment should be conducted with reference :

1st. To the anatomical lesion involved—by means of local applications, among which the preparations of tar, aided by emollient, alkaline, or sulphurous baths, douches, etc., deserve the preference.

2d. To the constitutional cause, which should always be carefully sought for, and will determine the general treatment of the case.

3d. In every instance, to the co-existing state of debility—by tonic medication, and attention to dietetic, hygienic, and climatic conditions.—VINCENT (*Th. de Paris*, 1882).

TREATMENT OF CUTANEOUS SCROFULIDES IN CHILDREN.

I. THE best mode of treating cutaneous scrofulides of children is by scraping, followed by the thermo-cautery. Scraping removes the diseased tissue, and cauterization completes the work by destroying the pathological elements which have survived the former process, and by setting up a benign and reparative inflammation.

II. After every operation for scrofulide of the limbs, an air-tight dressing (*pansement par occlusion*), with strips of diachylon plaster applied in the manner elsewhere specified, will be found of great advantage, by repressing the tendency to exuberant granulations. The sore heals more rapidly, and the resulting cicatrix is thinner and more flexible than when the usual bandages are employed.

III. This kind of dressing, however, is almost impossible of application on the face and neck.

IV. Local treatment of scrofulide should always be resorted to in aid of constitutional measures. Only the former will avail to arrest a suppurating process

which has lasted for several years. Without local treatment, too, the little patient is liable to be more or less disfigured by the cicatricial keloids which will inevitably be produced.

It is in cases of tuberculous scrofulide, against which the best-directed constitutional treatment is generally powerless, that local measures are of the greatest utility. By destroying the tubercles at the outset of their development, they will effectually check the progress of the evil.—SABATIER (*Th. de Paris*, 1882).

BACTERIUM DECALVANS, AN ORGANISM ASSOCIATED WITH THE DESTRUCTION OF THE HAIR IN ALOPECIA AREATA.

THE author's special microscopic examinations in the year 1881, led him to believe that he had detected the presence of organisms in the roots of diseased hair, and he has furthermore obtained conclusive evidence that treatment designed to arrest the development of the organisms and mechanically to prevent their transportation from one hair to another, is sufficient to arrest the disease. This treatment consists simply in the free use of sulphur ointment.

The facts presented and the theory founded on them are summarized under their respective heads as follows :

1. The facts are, that minute bodies of definite and fixed shape and size are found in and on the hairs in alopecia areata. These bodies are distinct from the granular elements present in hairs, and are neither oily particles nor crystals. They are of the size and shape, and have the refractive qualities of, bacteria. When present in small numbers on the shaft, the hair is entire : whilst within some hairs, much affected by the disease, they were found in great numbers.

2. The theory is, that these bodies are bacteria, and that the disappearance of the hair is due to a breaking up of the hair shaft by the multiplication in it of the organisms.

It is added in a note that subsequent recent investigations have confirmed the author's views regarding the existence of this bacterium. He has now observed it in all the phases through which a bacterial organism may be traced, and will shortly be able to publish an account of methods by which it can be more rapidly observed.—THIN (*Brit. Med. Jour.*, 1882).

CASE OF PRURIGO.

SURGEON SHIRLEY DEAKIN, of Allahabad, India, reports a case of this disease, which came under his care four years ago, in the person of a Punjaub Mussulman, aged 52. The patient was terribly tormented with a constant itching of the entire surface of the body, except the palms of the hands and soles of the feet. The whole of the skin, except that over the scalp, chin, arm-pits and groins, was much infiltrated and thickened. When uncovered he shivered greatly. His beard had fallen out, as also the hair of his scalp and chest: the moustache was firm. After a two months' course of hospital treatment with a variety of remedies, including a solution of arsenic, he left for home, no better. Two months later he was re-admitted, still unimproved. Alkaline baths, and a lotion containing hydrocyanic acid and borax, together with powdered ergot internally, having been employed for several weeks, he at last resumed the solution of arsenic, taking five minims three times daily. Numerous small, raised and reddened lumps, somewhat resembling mosquito bites, only much larger, now made their appearance on the skin. Under this treatment his condition greatly improved, and in four months from his re-admission he was convalescent and discharged. When

examined four months afterwards, his beard and hair had grown again luxuriantly, and of a much darker color than before his illness.—*Lancet*, Oct. 21, 1882.

CONTRIBUTION TO THE STUDY OF CERTAIN TROPHIC TROUBLES OF LOCOMOTOR ATAXIA.

(*Spontaneous Fall of the Teeth and Nails.*)

1. The fall of the nails (great toe) in locomotor ataxia is a spontaneous phenomenon, without appreciable efficient cause.

2. This fall takes place during the second period of the principal disease: in certain cases a sharp pain in the toe preceded, for some time, the fall of the nail.

3. The nail separates itself and falls insidiously, without pain, and after a certain time it is reproduced, more rough and more uneven than in the normal condition.

4. In certain cases only, a sub-ungual ecchymosis precedes, and in some way occasions the fall of the nail.

5. The spontaneous fall of the nails is, like the loss of the teeth, of trophic origin.—HAY-MARGIVAUDIERE (*Th. de Paris*, 1883).

ERYSIPELATOUS ERUPTIONS PRODUCED BY ARNICA.

L'Union Médicale for August 17 contains a report presented to the Société de Médecine of two cases in which the application of pure tincture of arnica for the relief of contusions was followed by well-marked symptoms of vesicular erysipelas. Both subjects were females, having lymphatic constitutions and fine, sensitive skins, and the affection in both was entirely local.

The reporter, M. Laissus, cites a number of authorities who have noted the irritating effects of arnica on the skin, but has only found one writer (Ruddock), who has mentioned it as producing erysipelas. He concludes that, in view of its influence upon certain constitutions, this agent ought always to be employed in a state of dilution.

RHEUMATIC PURPURA.

1. HEMORRHAGIC purpura, considered as a rheumatismal phenomenon, occurs (although rarely) either synchronously or in alternation with, before or after, the other manifestations of the rheumatic diathesis.

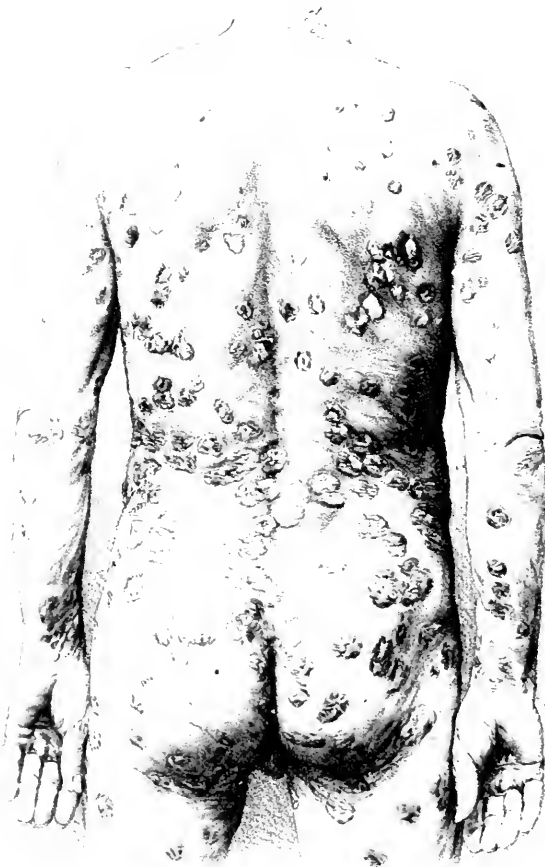
2. The punctiform hemorrhage characteristic of the disease is not, probably, confined to the outer integument, but may be inferred from the accompanying gastro-intestinal symptoms (sometimes including even bloody stools), to take place also from the surface of the digestive tract. This is in accordance with the sympathy which has been proved to exist between the skin and the bowels.

3. Purpura.—A closing symptom of cachexia in Werlhof's disease, in scurvy, and in many other dangerous affections as well as in cancer, Bright's disease, advanced cardiac disorders, etc., is comparatively harmless when of a rheumatic nature, or occurring in the course of rheumatism.—NATU (*Th. de Paris*, 1882).

THE AMERICAN DERMATOLOGICAL ASSOCIATION will hold its Seventh Annual Meeting at the Sagamore, Lake George, August 29, 30, and 31.



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ON THE POLYMORPHOUS CHANGES IN THE TUBERCULAR SYPHILIDE.¹

BY

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I HAVE had under observation, during the past five months, a case of the tubercular syphilide which has presented many points of interest, as showing the tendency to polymorphism in syphilitic eruptions. As is well known, the usual tendency of the tubercular syphilide is to extend peripherally, while it heals in the centre, thus illustrating a striking feature of syphilitic processes, especially those of the skin, namely, a synchronous evolution and involution; in other words, in the proportion that hypertrophy occurs, a more or less proportionate atrophy also goes hand in hand with it. While, in general, an hypertrophic and serpiginous course is the one observed in the tubercular syphilide, in some less frequent instances degenerative changes occur in it, and it is to this rather unusual course in the case I now detail to which I wish to call attention here.

W. R., aged forty-seven, a widower, native of France, was admitted to Charity Hospital, April 2, 1883. He was a man of good habits and, prior to two years ago, had enjoyed good health. In early life, he became bald upon the forehead and vertex, an accident which he claims was peculiar to his family. He has a large, prominent wen on the right temporal region, and a right indirect inguinal hernia. In the month of February, 1881, after a suspicious intercourse, he had a sore on his penis, the incubation period of which could not be definitely settled. No history of an early erythematous syphilide could be obtained. The sore healed promptly and was not attended with a bubo. In August, a general papular eruption, in all probability a large papular syphilide, ap-

¹ Read before the American Dermatological Association, Aug. 30, 1883.

peared over whole body: he also had well-marked mucous patches. This eruption lasted two or three months, during which time the patient was under an active mercurial treatment. With the disappearance of it, all treatment was stopped, and for a year he had no dermal lesions, and took no medicine. Five months ago, in November, 1882, a second rash of large papules appeared over the whole body. During this period of five months, he was not systematically treated. On admission, I observed the following appearances: Symmetrically distributed over the body were large, flat, scaly patches, slightly elevated, in some regions grouped, in others sparsely scattered. The palms, soles, and knees proper were free from any patches, but they were present on the elbows. On the scalp, they were quite numerous but isolated; there were a few on the forehead and in the eye-brows; on the neck and the supra and infra clavicular region but few and much smaller patches were to be seen. They were particularly numerous over the anterior and posterior aspects of the trunk, and in rather greater numbers on the outer than the inner aspects of the limbs, upper and lower. While, in general, the patches were discretely scattered in some places, two or more had coalesced. The general appearance was strikingly suggestive of a general and well-marked case of psoriasis, and several physicians present at the earlier examinations of the patient made that diagnosis. Indeed, in almost every particular were the characters of psoriasis to be seen. There were small patches of reddened and thickened skin covered with imbricated scales. There were larger ones in which the centre was depressed and free from scales, but yet surrounded by a more or less complete ring of silvery adherent scales. Then again, in but one region, namely on the scalp, were the patches of a distinct coppery hue. Elsewhere the patches varied in color from a well-pronounced red to a deep-purple color. This latter tint was particularly well marked on the back. All of the patches had a well-marked areola of from one-third to one line and even more in breadth. Though the general appearance seemed to indicate that the case was one of psoriasis, I made the diagnosis of syphilis, and pronounced the eruption the non-ulcerating tubercular syphilide, with a rather unusual amount of scaling. For reasons which I need not give, a mercurial treatment was not immediately adopted. The case was thereafter watched by me very critically, and I will now detail the various changes which were observed in these patches. While, in general, the smaller patches resembled psoriasis in a distinct manner, careful observation showed, in the larger ones, changes not observed in the non-specific disease, and frequently seen in the tubercular syphilide. Thus, if the centres of large patches were scrutinized, in some a distinct but not deep atrophy could be seen. The appearances were those of superficial thinning and condensation. When the scales were removed from a patch, in some cases a

slightly thickened and reddened skin covered with a thin shining film, as is sometimes seen in psoriasis, was observed; in others, the scales were so firmly adherent that their removal required some force, and a slightly raw and moist surface was exposed. For about ten days, this condition remained unchanged, and there might have been a doubt as to the correctness of my diagnosis; but, from this time on, numerous degenerative changes occurred, the study of which is at once important and interesting, and which confirmed the diagnosis beyond any possibility of doubt. But before I speak of the degenerative changes, it is well to speak of the phases which the eruption assumed prior to their occurrence. Under the influence of simple vaseline frictions which were used as a placebo, the scales from the larger patches were soon removed. Then, upon the tolerably smooth patches, scales began to appear, particularly at their periphery. These scales formed segments of circles which increased in size until more or less fully-formed rings of these scales were formed. In this period, the eruption, in appearance and evolution, resembled psoriasis; but, from this time on, the changes were deep-seated. Thus, the patches or tubercles extended in area and increased in height very markedly, so that their salience above the skin level was, in most instances, fully one line. In many places, this hypertrophy of the patches did not at all differ, in appearance, from that of exuberant psoriasis, but in some spots, chiefly seated at the scalp, and on the anterior aspect of the trunk and the upper and lower limbs many patches were seen to be composed of a soft tissue. Thus, when the scales were removed, there could be seen, in the whole extent of small tubercles, and chiefly on the margins of the larger ones, minute little elevations of a coppery colloid tissue, soft to the touch, and, in every particular, similar to the colloid tissue seen in lupus. Beginning in spots, this tissue increased in height and in breadth, and then fused together, so that numerous patches thus came to present the appearance of colloid tubercles. While this change was taking place in the substance of the derma, there was little change in the epidermal layer, since few new scales were formed, and from many tubercles the scales which had been present fell off.

At this time there could be no question as to the diagnosis of syphilis, since the features of the eruption resembling psoriasis were nearly gone, and it was evident that the infiltration of the skin was the essential lesion, and the exfoliation only secondary to that. At this time then, there were scattered over the whole body two orders of tubercles, first, those of colloid tissue, and second, those of a firm tissue similar to that of the ordinary syphilitic papule or tubercle. Some of these tubercles—those on the head—were of a distinct coppery tint, while those on the body varied in color from a red to a deep purple, the latter color being most pronounced on the back, as shown in the chromo-lithograph. It

seems that the patient was at this time in what we may call an explosive period of his syphilis, for at this time degenerative changes began in those tubercles which during the preceding fortnight had been the seat of hypertrophic changes. Thus in the tubercles on the scalp might be seen scattered through the colloid tissue little greenish-yellow points, in some tubercles three or four, in largest ones as many as ten. As these yellow punctæ were watched day by day, it was readily seen that they grew in height and in area until they finally coalesced, and then on the site of the tubercle there was a distinct flat bulla filled with thick pus. The transformation was complete. Had any one seen the case then for the first time, he would have pronounced it one of syphilitic pemphigus, or rather one of the bullous syphilide. The bullæ were characteristic in all respects as to their base, contents, and epidermal envelope. But this stage of the eruption, which was most clearly marked on the scalp and shown in the chromo-lithograph Fig. 2, was of short duration, for very soon the bullæ became flattened, of a darker color, and in four days their place was filled by dark, blackish-brown crusts, resembling the dirt of the oyster shell, and in every way characteristic of syphilis. These crusts also underwent change. They became thicker and more salient, and in a measure laminated so as to resemble rupia. But in one or two instances true rupial crusts were formed, these being on the right eyebrow at the base of the nose, and on the cheek. Had the case been seen at this time, it would have been pronounced rupia without hesitation. While these changes were taking place in the colloid tubercles, the firmer form of tubercle was also undergoing change. Indeed, great activity of development began about this time, many of the patches or tubercles increased in area and height, and at the same time their epidermal crusts underwent increased development. Thus some small ones increased in area, and in the end were conical in shape and of a dirty brown color, somewhat like rupia and very like the patches figured in McCall Anderson's brochure on psoriasis and lepra, under the title psoriasis rupioides. The crusts covering the larger patches were less conical, but from their appearance it was readily seen that they belonged to the same class as did the smaller ones. From careful study and observation, I am led to think that the following changes took place in these tubercles: First, there was an increase in the amount of the granulation tissue in each tubercle; second, the increase was attended by a nearly synchronous degeneration of this tissue in a mild form, stopping short of producing ulceration; and thirdly, that coincident with these deeper changes, there was profuse proliferation of the epidermis. Thus then we had tubercles of granulation tissue in a quasi degenerated state, surmounted by little imbricated masses of compact epidermis. I examined these crusts with the microscope and found pus cells and epi-

thelial cells. This observation, I think, warrants the suspicion that the so-called psoriasis rupioides of Anderson and Tilbury Fox is really a form of the late papular or of the tubercular syphilide. In one instance I saw it well developed in a patient who had suffered from psoriasis for years, and had contracted syphilis. His rash was of the large papular kind, and many of the papules came to resemble the lesions so clearly shown in Anderson's plate already spoken of. While therefore I only put forward the suggestion that the eruption so well described by Anderson under the title psoriasis rupioides is more or less remotely dependent on syphilis, I think that the points brought out by this case are of especial importance, if not of warranting an opinion, certainly of giving color to a strong impression.

In addition to these changes thus far described, others of a graver character took place on the legs. The middle third of these members had been the seat of an old infiltrated eczema, which had been cured, but was followed by thickened and condensed state of the skin. Over this degenerated skin were seated a number of tubercles; coincidently with the explosion of degenerative changes before described, hyperæmia and hypertrophy appeared in the integument of this region, so that in a week it presented the exact appearance of gummatous infiltration. The subjective symptoms of an incipient eczema were wholly wanting, since there was neither heat nor itching, but on the contrary a thoroughly sub-acute condition. While the hyperæmia and thickening of the skin of the legs was increasing, the scaly tubercles underwent change. Their epidermal covering was cast off, their surfaces became first eroded and then ulcerated. Then the ulceration increased in area and depth until there were several large ulcers which had every characteristic of gummata. It is probable that at this time the tubercles were the foci of inflammatory infiltration, and that the region of the middle third of the leg thus came to be the seat of gummatous deposit, which underwent degeneration. All of these changes took place within a month, then active treatment was instituted, and the lesions began to slowly disappear. The crusts fell, leaving more or less atrophic patches, the tubercles subsided, and in some places there were no evidences of subsequent atrophy, while in others it was evident that absorption of the skin had occurred. In none of the spots left was there evidence of very deep atrophy. When last seen, a few days ago, the man's body was free from active lesions.

To sum up: The points of interest of the case are, first, its resemblance to psoriasis; second, the colloid degeneration of some of the tubercles coincidently with the increase of granulation tissue in others; third, the degeneration of the colloid tissue into pus and the formation of bullæ; fourth, the evidence offered that true bullæ may appear in syphilitic subject, though they result from degeneration of tissue rather

than from the effusion of serum and pus, as occurs as the rule in simple pemphigus; fifth, the development of tubercles having thick imbricated conical epidermal crusts appearing like rupia; sixth, in the suggestion offered by these lesions that perhaps the psoriasis rupioides of authors is more or less dependent upon syphilis; seventh, the formation of true rupia crusts from the bullæ above spoken of; eighth, the fact that the non-ulcerated tubercular syphilide may be the starting-point of severe and extensive gummatous infiltration.

GENERAL EXFOLIATIVE DERMATITIS.¹

BY

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Toronto, Ont.

THE term Exfoliative Dermatitis was adopted by Erasmus Wilson (1870), in his description of a form of disease which he considered really identical with that described by Hebra under the head of Pityriasis Rubra. It has since been applied to a number of cases which, although they resemble pityriasis rubra or eczema squamosum, still cannot be classed with either of these diseases. The definition given by Hebra of the former disease, in which particular stress is laid on the absence of infiltration, papules, vesicles, or pustules, and on its almost certain fatality, excludes many cases of exfoliative dermatitis.

Eczema squamosum universale, on the other hand, does not present those severe constitutional disturbances, nor the rapid onset which are often marked features of exfoliative dermatitis. The literature of this subject is not extensive. The number of cases recorded of all forms of this skin affection is not at all in proportion, in my opinion, to the frequency of the disease.

Dr. Fagge (*Guy's Hospital Reports*, 1868) describes a case which very closely resembles the pityriasis rubra of Hebra. It terminated fatally.

Dr. Pye Smith (*Guy's Hospital Reports*, 1877) also describes a fatal case which presented, besides desquamation, a vesicular eruption. Dr. Fereol presented to the *Société des Hôpitaux* a case of acute recurrent exfoliative dermatitis which very much resembled two which I am about to describe.

In the *Archives of Dermatology*, July, 1878, Dr. Bulkley reported a case of the acute variety, in whom six attacks occurred between the eleventh and fourteenth, and four between the eighteenth and twenty-third year of his age. The disease was confined to the upper and lower extremities.

Dr. G. H. Fox, January 9, 1879, presented a case at the New York

¹ Read before the American Dermatological Association, Aug. 30, 1883.

Dermatological Society, in whom the disease recurred annually, and extended over the whole body. The attacks were acute in character, lasting two or three weeks, and strongly resembled scarlet fever.

In the *British Medical Journal*, July 19-26, 1879, there appeared a very able article written by Dr. Baxter, in which he gave the histories of five cases. The first two were rapid in their course and terminated fatally, each lasting eight or ten weeks. The constitutional symptoms throughout the disease were very severe in both cases. The third and fourth cases recovered after some months' treatment. In all four the disease was marked at times by the presence of vesicles, bullæ or pustules. In the fifth case, a child, the affection appeared first in the form of an acute bullous eruption, which terminated in general exfoliative dermatitis. Recovery took place after two or three weeks' illness.

In the same article Dr. Baxter tabulated cases under four heads, which had been published up to that time :

(1.) Primary exfoliative dermatitis, of which eight cases were given.
(2) Exfoliative dermatitis, supervening on eczematous affection, six cases.
(3) Supervening on psoriasis, two cases. (4) Supervening on pemphigus. One of the latter is the case reported by Dr. Sherwell in the *Archives of Dermatology*. This list includes those reported by Wilson, Devergie, Hans Hebra, Percheron, Hutchinson, Fagge, Sparks and Guibout.

In the April, 1880, number of the *Edinburgh Medical Journal*, Dr. Jameson records six cases of exfoliative dermatitis. In three of these the disease ran a chronic course, and in three it was more or less of an acute character. In one of the acute cases there were recurrences. All except one recovered.

I have been able to collect thirty-four cases, including those tabulated by Dr. Baxter. Of these, eleven were fatal, ten entirely recovered, and in seven the recovery was partial, or the result was not known. In eight cases it ran an acute course, not lasting longer than a few weeks, and in twenty-five it was chronic, lasting for months or years. I have had under observation four cases of general exfoliative dermatitis, two of which were of a chronic character, and two were acute and recurrent.

CASE I.—W. S., æt. 68, a member of the city fire department. Patient, up to the attack for which I treated him, had enjoyed excellent health, and looked at least ten years younger than he really was. In the latter part of December he was bitten on the arm by a lady's dog which his son had just brought from the north.

The wound did not heal up quickly, and in the early part of January, about two weeks after the injury, a redness of the skin appeared on the wounded arm and extended to the shoulder. It spread rapidly over the trunk and extremities, so that in about ten days the whole body was involved. During the first few weeks he suffered from chills, followed by feverish spells. Throughout his illness he was sensitive to the slightest change of temperature. In twelve or fourteen days after the onset of

the disease desquamation commenced, and after the first four weeks became very profuse. During the month of February he presented the following appearance: The surface of the skin over the whole body was of a bright-red color, partially covered by scales. The scales were for the most part small and imbricated over the shoulders and arms. They were easily rubbed off, and every morning the bed linen was completely covered by enormous quantities of scales.

So far as I could observe, no vesicles or pustules existed throughout the course of the disease. There were in some places deep furrows. There was very little infiltration. The patient became fretful and peevish, although naturally he was of a cheerful disposition. During the second and third month of the attack his health ran down very much. His pulse was rapid and temperature elevated, ranging between 99 and 101° Far. He was at times delirious, and suffered very much from insomnia. Two large abscesses formed, one on the neck and another on the shoulder.

In May, about five months after the commencement of the disease, he began to improve. The redness and scaling gradually disappeared, so that it was only found in patches. By midsummer he was able to leave the house, and in a year from the beginning he was almost free from the disease. Although seven years have elapsed, he has had no recurrence, and after the second year no tendency to local eczema.

Many forms of treatment were adopted, but that which appeared of most benefit was bathing and the protection of the surface with emollient applications. Arsenic was of no use. Large doses of quinine were administered during the first two or three months, on account of these very constitutional symptoms.

CASE II.—This case has already been reported in the *Canadian Journal of Medical Science*, under the head of Pemphigus Foliaceus. I will give the main features of the case. Patient fifty-five years of age, suffered from a bullous eruption which began on the chest, and spread over the whole body. The bullae were not tense, being only partially filled with a clear transparent fluid, which afterwards became cloudy. In ten or twelve days the bullae with contents formed thick scabs or scales, which fell off, leaving a congested surface, from which profuse desquamation took place, which lasted some weeks.

The epidermis came off in large flakes or patches.

During the year during which he was under observation he had three or four different attacks, in which the eruption began on the chest and spread over the whole body. He was not at any time entirely free from the eruption. In the month of May, twelve months after the commencement of the disease, purpura was developed, with excessive irritability of the stomach. Death from asthenia followed.

This was, in my opinion, a typical case of pemphigus foliaceus, as it is described by Hebra. It appeared to me at the time that the subsequent desquamation was excessive, and formed a very prominent feature of the disease.

CASE III.—Recurrent exfoliative dermatitis. Mr. S., butcher, æt. twenty-nine. Patient has enjoyed good health, with the exception of the attacks about to be described. He is a corpulent man, with a fresh, fair complexion. He has had the ordinary diseases of childhood, including scarlet fever.

When eighteen years of age, in November, he had the first attack of exfoliative dermatitis. I did not see him in it, but was told that it resembled the second one, which I shall now describe. This came on when he was twenty-one years of age. It began by a dull pain, which was followed by fever. Twenty-four hours afterwards he noticed a redness of the skin, beginning first on the chest, and spreading rapidly over the trunk and limbs. The redness continued for three or four days, when desquamation commenced. The epidermis came off in large flakes. The scaling was universal. In about two weeks after the commencement of the attack, the desquamation ceased, and he was able to leave his bed.

At the end of the following two weeks, he had quite recovered his strength. During the eruptive stage, the temperature ranged between 99 and 102°; pulse, 90-100. There was great prostration; the patient was two weeks in bed. The skin in the latter stages was very itchy. The mucous membrane of the throat was somewhat congested, but he did not complain of it.

When twenty-five, he had a third attack, for which I treated him. This one occurred in February, when the weather was excessively cold. It resembled as nearly as possible the one already described, except that it was more severe.

When twenty-seven, in the month of August, he had a fourth attack. This ran a much milder course than the others. He dreaded the disease so much that at the onset he sent for me, although it was in the middle of the night.

I found him with a slightly elevated temperature, pulse about 100, and complaining of headache. The redness of the skin had not commenced, but he knew from the peculiar sensation which he experienced that it would soon follow. A powder of pulv. jalapæ co. was administered, to be followed by large doses of quinine. On the next day, the redness appeared on the face and in front of the chest. It did not, however, extend over the whole body, as in the former attack. Desquamation followed rapidly, and he was quite well at the end of the first week. The highest point the temperature reached was 102°. In this last seizure the symptoms from the beginning were not so severe, and it is doubtful whether or not the treatment had any influence in mitigating the disease.

The patient is now a strong, healthy man, but very much dreads another attack.

CASE IV.—Recurrent general exfoliative dermatitis. Miss D., æt. nineteen, has dark hair, blue eyes, and a clear complexion. Patient's family at one time wealthy, is now in reduced circumstances. She helps to support her mother by giving music lessons. Although never strong, she has not had any severe illness. She had scarlet fever when six years of age, and, according to her mother's account, inflammation of the lungs on two occasions. Four years ago, small watery blisters appeared on the hands which were considerably swollen. She was then at boarding school, and had not been exposed to any irritant. Immediately afterwards an eruption very similar to scarlatina appeared on the body and became universal. She had to remain in bed about three weeks, suffering from moderately high fever, with rapid pulse; the face and eyelids

were much swollen. In a few days the fever subsided, and the epidermis came off in large flakes. The whole attack lasted about three weeks.

Three years ago, in the month of July, she had a second seizure, very similar to the one already described, which lasted about the same length of time.

Last summer she had a third attack in the month of June. It was not so severe as previous ones, lasting about two weeks.

About four weeks ago, in the middle of March, she was seized with what appears to have been herpes zoster. This lasted about a week, when the fourth attack of dermatitis commenced. It was ushered in in the usual way by high fever and rapid pulse. She was in bed about four or five days, when desquamation began. In about four weeks it had entirely ceased, and she was rapidly regaining strength.

These notes were taken April 15, 1880. The patient I saw only during the latter half of the last seizure. The information with regard to the others was obtained from her attending physician. She has not had any more attacks and is now in good health.

It will be noticed that in Case III. the seizures occurred at various seasons of the year, and in Case IV. the first three took place in summer and the fourth in March. In both the disease ran a very similar course, except that in the latter there was at the commencement a vesicular eruption, whereas in the former no such lesion occurred. There was no albumen in the case so far as known. If in these two last cases there had been but a single attack, the disease would have been called scarlatina, and it is probable that many cases of general exfoliative dermatitis have been mistaken for that disease.

The principal features of the disease may be divided under three heads: (1) General hyperæmia, (2) general exfoliation of the epidermis, (3) severe constitutional symptoms appearing at various times throughout the attack, and in many instances a tendency to a fatal result. In some cases preceding the hyperæmia and exfoliation, there is a serous exudation. This occurred in the second, a chronic case, and in the fourth, which was acute. In the second case, which I previously described under the head of pemphigus foliaceus, the changes took place in the skin as follows: (1) A softened, macerated condition of the epidermis; (2) the formation of bullæ with slight hyperæmia at the base; (3) desiccation took place and hyperæmia increased; (4) exfoliation of flakes of epidermis from a reddened congested base.

From my observation, I agree with Dr. Baxter and Dr. Jamieson in the opinion the term general exfoliative dermatitis may be applied to all the cases which are generally described under the names of pityriasis rubra and pemphigus foliaceus, as well as to other cases which cannot be classed with either. Baxter still uses the term pemphigus as applied to the first stage of that form of exfoliative dermatitis.

It will be seen, I think, on looking up the cases which have been re-

ported, that there are two principal subdivisions of this disease, the acute and chronic. Of the latter, we have two varieties; one in which hyperæmia and exfoliation exist might be called dermatitis exfoliativa rubra; and a second, in which a serous exudation in the form of bullæ precedes the exfoliation, might be termed dermatitis bullosa et exfoliativa. The former variety would include pityriasis rubrum, and the latter pemphigus foliaceus.

The acute form, although often single, has a strong tendency to recur. These recurrences do not seem to be influenced by season or any outward circumstance. It will be seen by the two cases which I have given, that they were dissimilar in almost every respect as regards appearance and surroundings, and yet the attacks were almost identical. The recurrence may be accounted for from individual peculiarities. A very slight attack of inflammation of the lungs from slight and unknown causes may leave a tendency to frequent inflammation of the skin.

A CASE OF EPIDIDYMITIS.

BY

WM. L. AXFORD, M.D.

Chicago, Ill.

A YOUNG man, aged twenty-two, who had recently contracted his third gonorrhœa, asked me to see him, as he was suffering considerable pain in groin, and was afraid that his testicle was going to swell. I found that a well-marked attack of epididymitis had set in, and that the right testicle, which was involved, was the only one which had descended. Careful physical examination failed to reveal the whereabouts of the other. Rest in bed, elevation of the affected organ, anodynes, and the usual routine treatment was carried out, resulting in his recovery in a reasonable time.

On examination some days after he was sufficiently well to be about, the globus major was found enlarged, hardened, and tender, the globus minor being in a like condition. Curious to know whether his undescended testicle was of any value, and also desiring to know whether or not he was sterile, I asked for a specimen of his semen for microscopical examination. A careful examination showed that there was not a single spermatozoon to be seen, and that, though sexual desire and the ability to copulate were as perfect as ever, he was completely sterile.

An ointment was given him as follows:—

R Iodoform.....	3 ss.
Potass. iod.	℥i.
Ung. petrolei	℥i.

He was directed to seize the testicle so as to bring the posterior part next

the skin, and to thoroughly rub in a quantity of the ointment as large as a filbert, morning and evening. His semen was examined at intervals of a fortnight.

For some weeks no spermatozoa could be seen, but at end of two months they gradually put in an appearance, and finally the semen contained a normal quantity. The enlargement, induration, and tenderness also disappeared. Whether this happy result was due the action of the ointment, to the massage, or whether nature would have cleared out the obstructed ducts in time, I am not prepared to say.

THE TREATMENT OF ECZEMA.

BY

McCALL ANDERSON, M.D.

(Continued from page 363.)

ECZEMA of the hairy portions of the face (*eczema pilare faciei*) is an exceedingly common and a very annoying affection, owing to the disfigurement which it occasions, the burning heat which accompanies it, and the difficulty and pain of shaving. The only word in English dermatological works which is intended to denote it, is "impetigo menti"; but the disease is by no means confined to the chin, so that this name is a too restricted one. I have therefore called it "*eczema pilare faciei*," which is more correct, though perhaps not so euphonious.

The eruption commences by the formation of pustules, each of which is situated at the orifice of a hair follicle, for it will be noticed that a hair passes through the centre of each pustule. It is curious, though true, that *eczema* almost always assumes the pustular form in this situation in adult males—an observation which coincides with what has been previously stated, that the pustular form of *eczema* (*impetigo*) is much more frequently observed on hairy than on non-hairy parts of the body.

These pustules dry up into small, yellow crusts, which are difficult of removal, owing to their adhesion to the hairs as well as to the skin. When many pustules form at the orifices of neighboring follicles, they have a tendency to run together; and on drying up, large irregular yellow crusts are left. If these are not removed, successive exudations on the surface of the skin are confined by them, and lead to excoriations, and occasionally, owing to their continued pressure, to obliteration of the hair follicles, and permanent alopecia of the affected parts. The skin on which the pustules are developed assumes a dusky, red tint, and becomes gradually more and more thickened and infiltrated. The patient sometimes complains of itching, oftener of pain or burning heat—a sensation which is principally experienced during the formation of a crop of pustules, and

the disease is often kept up for months, or even years, owing to the occurrence of successive crops. When it occurs in strumous subjects, the surface has a tendency to assume more or less of a violet tint; the affection is then exceedingly chronic, and destruction of the hair follicles and permanent alopecia are much more certain to occur. These three features, when markedly present, indicate the necessity for the persevering use of anti-strumous remedies.

The causes which specially operate in the production of this form of eczema are, irritating discharges from the nose and mouth, and the irritation of blunt razors. Indeed, the disease may even disappear spontaneously when these causes are no longer in operation, if the predisposition to eczema is not very strong, and the eruption is not of long standing.

The diseases which are oftenest confounded with this form of eczema are tinea sycosis and sycosis non-parasitica (folliculitis barbæ), although the differences are generally very marked. The following are the points of distinction between eczema and ringworm of the beard:

Eczema pilare faciei.

Tinea sycosis (sycosis parasitica).

- | | |
|--|---|
| 1. Very common. | 1. Not so common, but by no means so rare as many suppose. |
| 2. A pustular disease only. | 2. Pustules, tubercles, and large fleshy indurations detected when disease fully established. |
| 3. No trace of tinea circinata either on the affected parts or in other localities. | 3. Rings of tinea circinata (ringworm of the body) sometimes detected among the hairs, and round the front of the neck, on the wrists, arms, or other parts of the body. |
| 4. Not contagious. | 4. Contagious, and often history of ringworm of the head or body in other members of the family, or of a "foul shave." |
| 5. Hairs healthy, and adhere firmly, so that epilation causes pain, unless much suppuration has occurred at their roots. | 5. Hairs brittle, broken, or twisted; have lost their natural glistening appearance, are thick and at times white: many of them can be extracted with perfect ease and without pain, and come away without their bulbs. |
| 6. No parasite to be detected. | 6. Fungus (the trichophyton) detected in some of the hairs and scales. |

Sycosis non-parasitica (folliculitis barbæ, acne sycosiformis) ought not to be mistaken for eczema, if we bear in mind that in the former tubercles and small abscesses are more prominent features than pustules.

In the treatment of this form of eczema, it must be borne in mind that it is generally a tedious complaint at the best, so that much perseverance is required, although the ultimate result is satisfactory; and that

strong local stimulants, such as the empyreumatic oils, are generally the reverse of useful. In fact, the local treatment should be carried out pretty much in accordance with the principles laid down in connection with acute eczematous eruptions. And yet it will generally be found that shaving the parts thoroughly every day is a necessary adjunct to other treatment, many cases yielding when it is resorted to which had previously resisted other remedies. The patient is very apt to say, "But I can't shave"; the reply to which is that, after removing the crusts, the operation, especially after the first few days, is by no means a difficult nor a very painful one. The soothing ointments generally indicated should be spread on pieces of linen, which are to be kept constantly applied, but some patients refuse to make use of them by day, which is the very time when the surface is exposed to the influence of cold winds, hot sun, irritating particles, etc., and most requires them; and under these circumstances the parts may be protected by means of Dr. James Provan's (of Glasgow) tragacanth paste.¹ Or the affected surface may be sprinkled with one of the dusting powders already mentioned.



The scoops devised by Auspitz, of Vienna (of which the accompanying is an illustration), are of great service. After shaving and applying linen spread with diachylon ointment, for several days, the most prominent pustules are opened with the conical point, and then the whole surface is firmly scraped with the scoop, so as to remove all pustules, crusts, etc. This process is repeated several times a week, the parts being kept covered continually, in the intervals, with the ointment. In this way, brilliant cures are often effected.

If, after a persevering trial of the means of cure just indicated, a satisfactory result is not obtained, all the hairs proceeding from the affected parts may be extracted, and a stimulating ointment, such as citrine ointment, applied, night and morning, to the affected surface. This treatment occasionally acts like a charm, and old-standing cases may occasionally be cured in a few weeks by means of it, and although it often fails to effect a complete cure, it is generally productive of tem-

¹ R Tragacanthæ.

Glycerini (Price).....āā 3 iv.

Boracis 3 ss.

Aquæ destillatæ.....q. s.

Fiat pasta.

Sig. Paint the part freely with the paste, and let it dry. It can be washed off with soft water.

porary benefit. After the parts have been once epilated, if new pustules appear, the hair passing through the middle of each must at once be extracted and the use of the ointment continued.

The following case illustrates the benefit of this mode of treatment.

Mr. M., aged about thirty-five, consulted me on April 24, 1861, with regard to an eruption on the upper part of the lip, immediately beneath the nostrils. The patch was about an inch square, the skin red and infiltrated, and numerous pustules and yellow crusts were situated at the orifices of the hair follicles. The disease was kept up by the formation of successive crops of pustules. He stated that he frequently had a discharge from the nostrils, which, he thought, irritated the skin of the upper lip. He had been taking Donovan's solution for some time when I saw him, and, he said, with benefit, and it was therefore continued.

A week afterwards, the eruption being in no way altered, Fowler's solution, at first in ten, later in fifteen-drop doses (thrice daily), was administered for some weeks, and an ointment of two drachms of citrine ointment, mixed with six of linimentum calcis, was rubbed firmly into the roots of the hair, night and morning. The arsenic, in one form or another, having been continued for a couple of months, and no benefit accruing from its employment, was omitted, and the morbid surface was touched gently with solid potassa fusa, after the removal of the crusts.

A week afterwards (May 11, 1861), great improvement was observed. The infiltration and redness of the skin were much less, but still a few pustules continued to form at the edges of the patch.

The patient was now lost sight of till January 23, 1862, when the eruption was found to be pretty much in the same state as when he was first seen, it having never disappeared entirely. I at once removed the crusts, extracted all the hairs, and ordered citrine ointment to be used night and morning.

Four days later (January 27, 1862), the infiltration and redness of the skin were nearly gone, and no new pustules had appeared. He was ordered to continue the use of the ointment a little longer, and if any new pustules appeared, to pull out the hairs which proceeded through the centres of them.

About two months after this (March 21), I saw this gentleman, by accident, when he informed me that, since the epilation, the disease had never reappeared, and no trace of the previous eruption could be discovered. He wore a magnificent moustache—epilation, as most are aware, having the effect of making the hair grow more luxuriantly than ever, owing to the stimulus which that operation gives to the circulation of the part.

Those who are alive to the benefits of a luxurious pair of whiskers, and who have not yet succeeded in the attainment of their wishes, may perhaps be inclined to draw a practical lesson from the results of epilation in the case of the gentleman just alluded to.

It may be as well to remark that epilation is only to be employed in very exceptional cases which have resisted all other methods of treatment

and that there is not nearly the same certainty of its doing good as in the case of ringworm of the beard.

In strumous cases, the best results are to be expected from the use of cod-liver oil, in full doses (two or three ounces per day), combined with the continuous application of the oil to the affected surface.

Eczema of the lips (eczema labiorum) is by no means of rare occurrence, and may coincide with a similar eruption on other parts, though they are often affected alone. The eruption may be confined to one lip, or both may be implicated, and they may be the seat of any of the forms of eczema previously described, the exuding and squamous varieties being the most common. They are often greatly swelled, the serum being diffused through the cellular tissue, the meshes of which are very loose. The oral aperture is often spasmodically contracted, especially if fissures complicate the eruption, as they often do, particularly at the angles of the mouth and the centre of the lower lip: and when the parts are the seat of exudation, the lips may be glued together when the patient awakens in the morning.

Hebra has observed eczema of the lips to be frequently associated with eczema of the anus, and he once had a patient who was affected alternately with eczema of the anus and lips.

The two diseases which are most apt to be mistaken for eczema of the lips are herpes labialis and syphilitic eruptions of these parts. But one will be little likely to fall into error, if the points already referred to in speaking of the diagnosis of eczema in general are remembered. There is just one additional circumstance, however, with which it is necessary to be familiar in connection with syphilitic affections of the lips, namely, that the eruption rarely affects the whole of even one lip, but has a marked tendency to concentrate itself, in the shape of elevated patches (condylomata) and fissures, at the angles of the mouth, where it is often obstinate, till the patient is brought under the influence of mercury, when it, "vanquished, quits the field."

Care must be taken in the use of strong solutions of poisonous preparations, such as those of corrosive sublimate, in the treatment of this affection; for it is quite possible for the patient to swallow a sufficiency of the mixture to induce serious symptoms. I have nothing to add, with regard to treatment, further than to refer particularly to the remarks already made upon the means appropriate for the removal of limited eczematous eruptions, and to remind the reader that eczema of these parts frequently occurs in connection with symptoms of digestive derangement, which must therefore be carefully inquired for and removed.

The following case of eczema of the lips is a good illustration of the eruption in question :

"A gentleman, aged about 35, came for consultation on April 15,

1861, on account of an eruption of eczema attacking both lips, and for the second time. A small infiltrated, exuding, and itchy patch existed on the right cheek, near the angle of the mouth, and occasionally vesicles were detected on it. The lips were slightly infiltrated, thickened, red, and itchy; the epithelium was constantly peeling off them, so that they were very rough, and sometimes a little serous fluid exuded, while fissures had formed here and there, but particularly at the angles of the mouth. His general health was excellent. Fowler's and Donovan's solutions were successively administered without effect, and the disease was finally and rapidly cured by applying 'aqua potassa' to the parts night and morning, and washing them frequently with cold water."

Eczema of the edges of the eyelids (eczema tarsi, ophthalmia tarsi, tinea ciliorum, is exceedingly common, especially in scrofulous children, and is often associated with conjunctivitis and strumous ophthalmia. The affection is neither more nor less than a pustular eczema (impetigo), attacking the edges of the lids (like that which so often attacks the beard, and with which it may be associated), although it does not seem to be always recognized as such by ophthalmic surgeons; for it commences by the formation of pustules at the orifices of the hair follicles, which concrete into scabs, beneath which the parts are found to be excoeriated; or small ulcers are detected; and when the disease is fully developed, the usual symptoms of eczema—redness, swelling, itching, infiltration, exudation, etc., are observed. The exudation from the morbid surface, mingled with the altered secretion from the Meibomian follicles, not only glues the neighboring hairs, but also the edges of the eyelids together, especially at night, unless proper precautions are taken. Lachrymation is likewise a common symptom, and the tears falling on the cheek not unfrequently irritate the skin, and may give rise to an eczematous eruption.

If improperly treated or neglected, as occurs too often, the pressure of the crusts, the confinement of the discharge, and the formation and extension of ulcers, lead ultimately to obliteration of the Meibomian glands and hair follicles, after which a perfect cure is of course impossible. Amongst the train of evils may also be mentioned inversion or eversion of the lids; and if the eyelashes are not gone, owing to obliteration of their follicles, the hairs are apt to assume abnormal directions. In exceptional cases pediculi (*Pediculus pubis*) attack the eyelids: the parts become itchy, and the scratching irritates and inflames the edges of the lids, thus giving rise to an appearance like that of the affection under consideration. But the discovery of the nits adhering to the hairs, or of the pediculi clinging to them close to the surface, should prevent error.

With regard to the local treatment, the extraction of the eyelashes is always followed by improvement. This operation is far too often omitted, for in my opinion it should be uniformly carried into effect

in bad cases when cutting away the hair has failed, and repeated if new pustules form at the orifices of the follicles, exactly in the same way as in the treatment of obstinate cases of eczema of the beard. If the parts are much infiltrated, it is sometimes useful, after the removal of all crusts, to apply a solution of potassa fusa (usually a solution of ten grains in an ounce of water) to the edges of the lids, an operation which should not be intrusted to the patient, at first at all events. A small brush must be used, and very little of the solution taken up by it, so as to make it moist, but no more. The eye-lid must then be carefully dried, else the application spreads, everted so as to remove it from the eyeball, and the solution painted along its edge. A large brush soaked in cold water should be in readiness, to stop the action when desired. This application may be repeated every day till the infiltration, exudation, and itching subside, after which diluted citrine ointment, or Startin's red ointment may be relied upon for completing the cure. In slight cases the eruption often yields to the use of mildly stimulating ointments alone, coupled with cleanliness, and in all cases during the treatment a little ointment should be applied to the edges of the lids at night, so as to prevent their adhesion, and removed in the morning. If, notwithstanding the anointing of the lids at night, they are adherent in the morning, they must on no account be torn asunder, but the agglutinated matter must be softened. For this purpose, says Mackenzie, "a teaspoonful of milk, with a bit of fresh butter melted in it, may be employed for smearing the lids, rubbing it with the finger gently along the agglutinated eyelashes. A piece of soft sponge, wrung out of hot water, is then to be held upon the eyelids for some minutes, after which the patient will find the eyelids yield without pain to the least effort he makes to open them. With the finger-nail the whole of the matter is immediately to be removed."¹

If there is any inflammation of the conjunctiva, Mackenzie's excellent wash of the bichloride of mercury² may be used with advantage,

¹ "A Practical Treatise on the Diseases of the Eye." By W. Mackenzie, M.D. Fourth Edition, p. 145.

² R Hydrargyri bichloridi.....gr. i.
Hydrochloratis ammoniægr. vi.
Extracti belladonnæ.....gr. x.
Cocci cacti.....gr. iss.
Alcoholis 5 i.

Tere simul, adde aquæ uncias sex, et cola per chartam.

Sig. Pour out half a tablespoonful of this fluid, and mix it with as much boiling water in a teacup previously warmed. With a piece of old linen or soft sponge bathe the eyelids with the mixture for a few minutes, and then, by leaning back the head, allow a little of it to flow in upon the eye. Repeat this thrice daily.

and is often sufficient when the conjunctivitis is slight. For the treatment of a more severe attack, as well as for that of the other complications of eezema tarsi, such as ectropium, entropium, trichiasis, ophthalmia serofulosa, etc., the reader should refer to special works on ophthalmic surgery.

(To be continued.)

Correspondence.

HERPES VULVÆ.

To the Editors of the Journal of Cutaneous and Venereal Diseases.

SIRS:—Having read with great interest in the August number of your JOURNAL an article by Unna, "On Herpes Progenitalis. Especially in Women," and the arguments therein adduced in support of its extreme rarity, except in cases of puellæ publicæ, I send you the following report of a case that occurred in my practice last spring, in which there was not the slightest reason to suppose the disease dependent upon the above-mentioned cause, *i. e.*, "vocation."

Mrs. K., widow, primipara, aged twenty-six, applied to me in April with the following history: From the beginning of menstruation, had always had dysmenorrhœa and menorrhagia, also leucorrhœa, for which, from lay advice, enemata of alum water had been employed per vaginam, but without relief. Married at eighteen, immediately after which she was placed by her husband under the care of a prominent specialist of this city, who, she states, treated her for uterine congestion, etc., with such success that conception soon followed, and she was delivered at term, after a tedious and severe, but natural labor. At the expiration of a year, both husband and child died. She stated that from time to time she has had recurrence of her old difficulties, for which she received treatment with iodine, etc., from the general practitioner by whom she was confined. When she came under my charge, she had just recovered from a severe attack of intermittent fever, complained of prostration, general malaise, pain during and after micturition, menorrhagia, leucorrhœa, and frequent pain in head and back.

Ocular examination revealed labia majora normal, but sufficiently distended to permit protrusion of nymphæ, which measured not less than one and one-half inch, from attached to free border; external surface dark, bluish, rougher and dryer than normal; cutis appeared wrinkled or shrivelled, like the "washer-woman's finger." On separating the parts, I discovered five or six erosions: the two larger and more painful occupied a site on either side of the clitoris, so close to the meatus as to render urination extremely painful. The remainder were located a little anterior to the fourchette. No appearance of a vesicle at that time existed.

Bimanual palpation revealed fundus slightly enlarged with prolapsus uteri of the first degree. The sound was not passed. Examination by speculum showed cervix elongated and congested, copious milky vaginal discharge, also the familiar albuminous leucorrhœa of cervical endometritis.

I could obtain no history of venereal disease, and was unwilling, from the absence of the characteristic appearance, to commit myself to a diagnosis of chancroid, while the *irregularly-rounded* appearance of the abrasions, with *borders described by segments of small circles*, led me to infer their origin to be *vesicular* rather than *pustular*, although, from the literature then at my command, I did not feel justified in the diagnosis of herpes progenitalis.

Prescribed an alkaline diuretic, hoping to render urination less painful, biniodide of mercury internally, touched the diseased parts with argenti nitras. grs. lxxx., aq. $\bar{\epsilon}$ i., and ordered lead-water and iodoform to be employed by patient.

Some days later, she reported general improvement, but suffered great difficulty in locomotion. Urination less painful, no tenesmus, etc.

Upon close questioning, she admitted excessive pruritus subsequent to each menstruation, so that it was almost "*impossible to avoid scratching and handling the parts.*" From one or two fissures that appeared, I had no reason to doubt the statement. She was, however, unconscious of any abrasions or ulcerations having ever before appeared about the vulva. Iodoform was then applied, and the patient steadily improved until the week previous to the next menstruation, when she reported herself entirely relieved.

At the end of two weeks, she came again, some two or three days only having elapsed since she had ceased menstruating. A fresh crop of these abrasions, but located somewhat differently, and more on the left side, were visible. This time, nitric acid was applied, followed by an emollient dressing, iodoform and bals. peru ordered locally, quinine and other tonics internally. Improvement more marked than before, but still a fresh abrasion would now and then appear. Complete relief, as before, during the week previous to the menstrual nixus.

Treatment, of course, had been employed throughout this period for the uterine congestion and displacement, which yielded readily: the former, however, manifesting a disposition to return, but, unlike the vulvar lesion, unmarked by periodicity. During Mrs. K.'s absence from the city, in June, menstruation again occurred, succeeded by a similar, though less severe train of symptoms.

She returned for treatment, but this time a day or two longer had intervened without any unpleasant symptoms.

The vesicular character of the eruption now seemed well-marked, as *was doubtless* the case throughout could inspection have been employed in its incipency, but the patient would usually delay until abrasions compelled her to seek assistance. I now employed Calvert's carbolic acid No. 1 upon each abraded surface; no iodoform was used. Immediate benefit resulted.

The great difficulty was to prevent the usual recurrence.

In this case, the herpes vulvæ seems to me to have originated primarily from the friction incident upon the irritation of the genitals, which we know is by no means infrequent with young widows whose marital relations are suddenly suspended: and, secondarily, upon the debilitated condition of the system resulting from an attack of intermittent fever. Causes precisely similar to those producing the disease in males, as stated by some authorities.¹ "Herpes occurs in males after attacks of cold, fever, etc., as well as a result of irritation, friction, chemical or otherwise, or as an essential neurosis."

CARRIE L. BLACK, M.D.

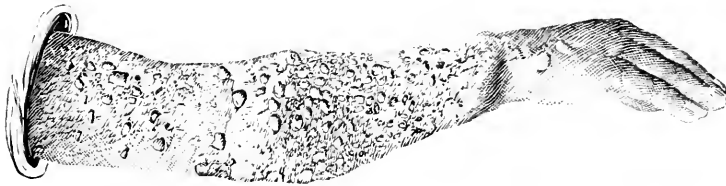
NEW YORK, Aug. 9, 1883.

¹ Keyes and Van Buren.

Editors Journal Cutaneous and Venereal Diseases:—

GENTLEMEN:—I inclose you herewith photographs of Chas. Wilson, colored. The case is interesting from the strong analogy his condition bears to some of the syphilodermata which frequently come under our observation, and would naturally lead the medical man astray in arriving at a diagnosis without a previous knowledge of the case. His arms, you will observe, are one mass of sores from his wrists to his shoulders: his legs are in like condition from ankles to knees. The eruption is tubercular in form, many of the tubercles in a stage of ulceration, discharging a peculiar grayish matter mixed more or less with blood, very offensive when allowed to remain for a time without cleansing the parts. The discharge is acrid in its properties, excoriating or scalding the surrounding parts painfully, leaving a widespread, angry-looking surface, mostly on his back and upper part of his legs.

The history of the case is briefly as follows: Wilson applied to me for treatment in July, 1882, stating that about two years previous, in August or September of 1879, he had a severe attack of cramp colic, for the relief of which he took



large quantities of chlorid hydrate and morphine. Failing to obtain relief from these drugs when administered by the mouth, resort was had to the hypodermic syringe. He continued the use of the morphine in this way for several weeks, taking from three to five injections daily. The condition for which the morphine was given having disappeared, he found that he could not do without the drug, and hence continued the use of it as long as there was a particle of surface into which the needle of the syringe could be inserted, until now his body presents the condition you see in the photographs. In July, 1882, when I first saw Wilson, he was taking from five to eight hypodermic injections daily, and had increased his dose of morphine from $\frac{1}{4}$ of a grain to from $2\frac{1}{2}$ to 4 grains at each dose, thus consuming in twenty-four hours from twenty-five to thirty grains of the drug.

I would state in conclusion that the morphine habit has been in a very large degree corrected by the use of the fluid extract coca, and a gradual reduction of the quantity of morphine, until now he takes it only about twice a week, and then only in $\frac{1}{4}$ or $\frac{1}{2}$ grain doses.

Respectfully,

Houston, Texas.

J. W. DANIEL, M.D.

Selections.

THERAPEUTICS OF THE HAIR AND NAILS.¹

BY PROF. P. GAMBERINI, M.D.

Pityriasis.

MALASSEZ adopts the following:

Cocoa butter,	
Castor oil,	
Almond oil.....	āā 20 gms.
Turpeth mineral.....	50 centgms.

Morning and night anoint the scalp; three times a week use soap. During the first few days of treatment a considerable loss of hair will occur, which would later have fallen out spontaneously. In addition thorough shaving, or, at least, keeping the hair short and brushing the head briskly to remove all the scurf and expose the parasites to view.

Pincus, speaking of *alopecia pityrodes*, remarks that arsenic, veratria, cantharidin, carbonate of potassa, etc., are useless. The irritation of the piliferous bulb, and of the elements which surround it injures the hair, and prevents their return. Tannin (gm. 4. to lard, 30), and, still better savin (oil of savin, 30 drops, to lard, gm. 30) are excellent remedies, especially in the first stage of the disease.

Alopecia Areata.

Excluding the parasitic nature of the disease in question, it is expedient to adopt a treatment which aims to combat those causes and morbid general conditions which, if they are not the true incitement of the area, serve to maintain it. These are anemia, scrofulosis, syphilides, lack of nutrition and of cleanliness and the like, as has been mentioned elsewhere. The local therapeutic aids consist of substances which stimulate by way of innervation or by way of the vascular system, and, according to some, of the vaso-motor system. The substances adopted by Hebra are the ethereal oils in alcoholic solution, the oil of mace, veratrine, tincture of cantharides, of capsicum, etc. The same dermatologist advises daily removal of the hairs, detaching them with the fingers over the entire bald spot until the hairs are found to be fixed. He states that he has in this manner observed a more rapid improvement. Tilbury Fox praises a mixture of tincture of nux vomica, distilled vinegar, and tincture of cantharides. Duhring says that alcohol constitutes the best base for the local remedies, adding to it tincture of cantharides, carbolic acid, liq. ammonia, etc. Wilson prefers ammonia united with camphor and chloroform. The clinical observations of Courrèges demonstrate the beneficial effects following shaving and mercurial frictions. He narrates, however, cases of spontaneous recovery from the disease which do not seem to accord with his parasitic theory. I prefer to employ the following mixture:

Sulphate of quinine.....	0.50
Tincture of camphor.....	40.
Liq. ammonia.....	3.
Tincture of cantharides.....	gtt. 10.

M.

¹Translated from Prof. Gamberini's recent treatise on Diseases of the Hair and Nails.

Applying the lotion to the parts twice a day, shaving, the application of electricity, and sinapisms have been advised. These remedies act as stimulants, and modify the nervous action.

The French school use the parasiticides, as in true tinea, which, in fact, act independently, perhaps, of the destruction of the parasite: they may conquer the disease by the irritant action which they exert on the nervous system.

Trichoptilosis or Trichorrhoeis.

Duhring asserts that cutting or shaving the hairs constitutes the best treatment, and that other local treatment has little effect, which has been confirmed by Beigel and Hebra. Schwimmer finds the following ointment advantageous:

R Floris zinci.....	0.5
Floris sulphuris.....	1.0
Ungt. simplicis.....	10.

M. Anoint the skin twice a day.

I have found it beneficial to wash the parts with a dilute alcoholic solution of carbonate of potassium or a mixture of tannin and oil of cade. I have observed benefit from cutting or shaving the head or beard, which, however, is not absolutely necessary, having recently seen a case of trichoptilosis of the beard, which had been very obstinate, recover by the prolonged and diligent use of:

R Carbonate of potassium.....	15.
Dilute alcohol.....	150.

M.

Devergie finds reconstituent treatment, and a proper hygiene of the scalp advantageous. Roeser praises an ointment made with rosemary. Beigel praises alkaline washes. Schwimmer commends sulphur, Kaposi tar.

Atrophy and Hypertrophy of the Hairs.

The true cause of atrophy of the hairs depends, in general, on their lack of nutrition, and hence it is proper to seek for the intrinsic cause.

Pilous hypertrophy, as met with in neoplasms and warts, or on the nipples, lips, chin, etc., of females, several methods may be used. Among these destruction of the neoplasm or wart, when not too extensive, by means of excision or cauterization. Hardaway, in circumscribed hirsuties, recommends electrolysis, inserting the needle as far as the bulb of the hair. In electrolysis, Piffard prefers a needle of irido-platinum and Fox fine platinum wire. Duhring and Bulkley implant a triangular needle in the follicle in such a manner as to destroy it. A needle merely heated in the flame of a lamp, and inserted as close to the hair as far as its bulb is equivalent to electrolysis. Some advise certain pastes made with orpiment, lime, sulphide of arsenic, etc., but such procedures, while sometimes accomplishing the purpose, occasionally produce disfiguring scars. Neumann says that the most simple method of treatment is epilation with forceps or shaving. Wilson recommends shaving. My own experience is in favor of epilation with the forceps, especially in connection with ladies' faces.

Favus.

It is generally conceded that epilation is necessary, in addition to parasiticides, such as corrosive sublimate, turpeth, oil of cade, sulphate of copper, carbolic

acid, etc., is necessary in the treatment of favus, as the parasite infests the hair follicle in its deeper portions, and substances applied to the surface merely are not sufficient. At the commencement of treatment, the hairs should be cut short with scissors, and cataplasms or emollients applied to soften the crusts and permit their easy removal. Afterwards, epilation is to be gradually accomplished, according to the extent of the disease, taking care to remove every hair, as, if a single diseased hair remains, it is sufficient to reproduce the trouble. It is also expedient to remove with depilatories the hairs which fail to be extracted with the forceps. In epilation, the traction should be made in the direction of the axis of the hair, in order that it may come out easily and entire. Afterwards, the paracitides are applied. In a short time, the hairs reappear, and those which appear diseased must be again removed. Several epilations, therefore, may be necessary. The signs of cure are a healthy hair, disappearance of the erythema, and the non-return of the favus at the base of the hair. The certainty of absolute cure can only be determined by microscopical examination. It is necessary, therefore, to keep favus patients under observation for some time, so that should any positive sign of disease reappear, it may be promptly combated. An eczematous or impetiginous eruption may accompany or follow favus, especially from the action of the parasiticide lotions employed. It is well to extend the epilation a little beyond the area of apparent disease, as the surrounding hairs may appear healthy, while, in fact, they may have already become attacked by the fungus.

It is claimed that the fungus is chiefly lodged in the horny layer of the epidermis, and consequently that this should be daily sponged with solutions of carbolic acid, corrosive sublimate, carbonate of potassium, sulphate of copper, etc. For this purpose, less powerful applications suffice, applied where the erythema, the pruritus, or the microscope indicate the presence of the fungus.

Favus situated on localities furnished with simple lanugo hairs is soon vanquished by detaching it completely, and applying iodine, carbolic acid, or a saturated solution of nitrate of silver.

In view of the vegetable nature of the fungus, I thought that by excluding the air it might be completely destroyed, and for this purpose removed the crusts, cut the hair, and permanently covered the skin with a mixture of collodion and sulphite of calcium, renewing the application daily. Three cases in this manner presented a favorable result. It must be admitted, however, that failure often occurred, which I attribute to the cracking of the collodion and the admission of air.

With reference to the highly-praised methods of treating the disease without epilation, I can only say that I have tried them all, and find them of little use. Whoever desires to know them may consult any modern treatise on dermatology. I therefore conclude that the true and rational treatment of favus consists in the use of epilation and parasitides, and all this is in accord with Bazin, Hardy, Duhring, Anderson, T. Fox, Behrend, Neumann, Hebra, etc.

The ancient method of the calotte with which the head was completely covered and the hairs made to adhere to it "and then pulled off with great violence," is a deplorable practice and is now abandoned. I have resorted to it only where the lanugo hairs were to be rooted out, and for this purpose employed little strips of linen smeared with the depilatory cerate of Gusberti or the like; these strips are superimposed in an imbricated manner, and then after a couple of days drawn off.

Internal treatment cannot aim to cure favus, as it is a purely local and exter-

nal disease; although it is useful and necessary to combat the morbid conditions that often accompany the pernicious action of the parasite, especially in those of tender years or surrounded by bad hygienic conditions.

As certain morbid conditions favor the development and persistence of favus, so, also, certain morbid processes are capable of hastening or accomplishing a cure. In this connection I refer to a case narrated by Schilling, of a little girl attacked with malignant variola, which nearly proved fatal, but was compensated for by recovery from the cutaneous disease; an occurrence which was explained by Schilling as the result of the variolous suppuration which attacked the piliferous follicle and destroyed the parasites.

Trichophytosis.

The treatment of this disease harmonizes with that of favus; it has equally the aim to destroy the parasite. The crusts and epithelial accumulations are to be removed by emollient applications, poultices and the like; this is to be followed by epilation when possible. The broken hairs are difficult of removal, and I therefore remove the hairs for a certain distance around the spot, in order to limit the territory for the diffusion of the fungus. The trichophytic spot having been laid bare, it should receive an application of some one of the various parasiticide substances already mentioned.

Lespian recommends the following :

R. Tannin.....	1.0
Tinct. iodine.....	10.0
Glycerin.....	20.0

M.

Apply this mixture twice a day for four days.

Chrysarobin was found useful by Squire, contrary to the experience of T. Fox and my own clinical experiments. Besnier prescribes the following :

R. Boracic acid,	
Flowers of zinc	5ā 1.
Vaseline.....	48.

M.

Ladreit de Lacharière treats it with croton oil applied to the spot where it develops a pustular eruption which destroys the fungus. Piffard, who praises this remedy, combines it with epilation. This oil, with white wax in equal parts, makes a cerate which, rubbed gently on the spot, provokes the necessary inflammation, according to its more or less frequent application. I use such a cerate with great benefit, especially in cases where epilation with the forceps is impossible.

Bazin, who may be regarded as the beneficent initiator of the successful treatment of trichophytosis, epilates the spot carefully and then bathes it with a solution of corrosive sublimate, or of sulphate of copper, or else anoints it with an ointment of turpeth, or with oil of cade; repeating the epilation if the returning hairs show signs of disease, and continuing the parasiticides daily until every trace of the disease has vanished.

Browne shaves a zone of healthy hair and covers the whole patch with rectified petroleum, rubbing it in strongly; when the spot has become quite red, he covers it with a mixture of tannin, iodine, and gum arabic, adding a little oil and covering the whole with a *compre* ½. This is repeated until the patch is covered with a thick stratum, which is left in position three or four days. The

crust is then to be moistened to remove it; repeating this medication until the parasite is totally destroyed.

Is epilation always necessary? When possible to execute, I believe it is indispensable for obtaining a prompt cure.

If the disease is accompanied with much inflammatory action, we should not use too strong applications, but rather adopt antiphlogistic measures, emollient lotions, starch powder, etc.

The treatment which I adopt with the patients of the out-door clinic, consists in cutting or shaving the hair and daily washing with soap, followed by frictions with an ointment of carbolic acid, or of iodine with oil of cade; in cases in which epilation may be necessary this is done by a trained attendant.

The other forms of trichophytosis of the trunk, eczema marginatum, herpes circinatus, iris, etc., are curable, more or less rapidly, by the use of some of the parasitic ointments mentioned.

There are patients who refuse epilation as well as shaving. In such cases Hebra prescribed one part of sublimate in two of alcohol, or chromic acid, and with this touched the spots; or else ordered an ointment of white precipitate, iodide of sulphur, etc.

When the disease is cured, it is known by the skin having returned to a normal color, by the reappearance of the hairs, by the absence of pruritus, etc. One must not, however, be deceived by appearances, as after two or three weeks the disease may show itself again; it is therefore necessary to keep the patients under observation for some little time.

In the treatment of kerion, the remedies indicated above are of value, kerion depending on the same parasite, accompanied with excessive tendency to supuration. Recently Dr. Raimondi, of Pavia, has treated and cured kerion by means of pyrogallic acid in the form of a thirty-per-cent ointment of vaseline, applied at first once, and then twice a day. Emollients are of service in reducing the inflammation, but whoever limits himself to bland applications will but rarely cure the disease. According to Fox, opening the abscesses is injurious. My experience, however, leads me to a different conclusion, and in this I am supported by Atkinson.

Since kerion is developed by preference in scrofulous and unhealthy children, such internal treatment as circumstances require should not be omitted.

Parasitic Sycosis.

The treatment is substantially the same as in the foregoing.

Wilson usually advises avulsion of the hairs and the application of parasiticide, especially corrosive sublimate, or iodide of sulphur in ointment (2—30).

Of the same therapeutical opinion are Tilbury Fox, Anderson, Behrend, Piffard, Duhring, Bazin, Hardy, and all those who recognize the parasitic nature of the disease. In my clinic I follow the following practice: As epilation is troublesome and often painful, I commence with emollient cataplasms in union with belladonna. After this I remove the hairs as completely as possible, and then apply the parasiticides, using by preference the oil of cade and tincture of iodine. When the sycosis is severe with extensive infiltrations, I avail myself of excisions and carbolic lotions.

It should be remembered that sometimes alcoholism, syphilis, scrofula, and arthritism complicate the trouble, and should be taken into serious clinical consideration and the appropriate remedies adopted.

Before treating the case, however, it is important to ascertain whether it is simple or parasitic sycosis.

Non-parasitic Sycosis.

If the disease is produced by a local cause, the removal of the same is necessary. The crusts are to be softened and removed by oily or slightly carbolated lotions. After this, epilation should be practised as in the parasitic form, inasmuch as the hairs act as foreign bodies and tend to prolong the inflammation. This is but an imitation of the mode employed by nature in her attempts to cure the disease. If epilation is not performed, the inflammation may run so high as to completely destroy the follicle. I therefore urge artificial epilation. This sometimes becomes troublesome, because the hair becomes firmly fixed during the early period of the peri-folliculitis.

The hairs having been removed, it is necessary to seek the resolution of the peri-follicular inflammation, which is accomplished with diachylon or Vigo plaster, with *sapo viridis* or potash, diluted with glycerin or vaseline. Sulphur, iodide of sulphur, white or red precipitate, or biniodide of mercury may be used. If the pus is deep, it must be let out with the lancet.

Plumbe and Wertheim recommend the daily shaving of the hairs. This method may have its advantages, but I adopt it but little, as it is usually disagreeable to patients, and does not compare in usefulness with epilation.

Duhring especially recommends external treatment, at the same time paying attention to the patient's general condition. He insists on the removal of the irritating causes, and the avoidance of the extremes of heat and cold.

Veiel cuts the hair short, and detaches the crusts with poultices, then applies an ointment composed of two parts of tar and one part of *sapo viridis*, and thus facilitates the extraction of the hairs. After the completion of the epilation, he applies acetic acid. This is followed by a crust which falls off in three or four days. These operations are to be repeated, completing the treatment with a sulphur ointment for four weeks longer. The shaving should be continued four months to prevent a relapse of the disease.

Stewart recommends the nitrate of potash dissolved in a large quantity of water, bathing the parts several times a day. He states that he has accomplished rapid cures.

Having observed that simple sycosis frequently co-exists with alcoholism and arthritism, I have resorted, with benefit, to the internal use of alkalies, and the external use of ointments, at first with a base of carbonate of potassa, and then of flowers of sulphur, always premising epilation.

In accord with Fox, I have seen advantage from the internal use of Donovan's solution, when the sycosis proceeded from herpeticism or was connected with syphilis.

Onychia Maligna.

In past times, surgeons finding the disease rebellious, resorted to severe measures. Vanzetti, instead of pulling out the nail, employed the powdered nitrate of lead to destroy the fungous granulations, as was proposed by Moerloose, in 1864. Paccione used to advantage the acetate of lead; Giacchi, quicklime, and Ceccato nitrate of lead with local anaesthesia. Mazzucchelli gives preference to the use of Lister's antiseptic spray, in three p.c. solution, having previously washed the part with tepid water and *com non* soap, without pulling out or cutting the nail. Then in order to prevent the irritant action of the acid he pencils the surface with glycerin. Rizzoli reports eighteen cases of the disease, in which ten

were treated with avulsion of the nail and eight with the nitrate of lead. He gives his preference to removal of the nail. Among the observations mentioned were four that demonstrated that the bromide of potassium acted as well as the nitrate of lead, either alone or with avulsion of the nail.

Incurvatio Unguium.

When the nail threatens to grow into the skin, or has already injured it, the first indication is to put on a sock of moderate size and to remain quiet. Afterwards the nail is to be scraped on the affected side till it is sufficiently thin: then it is to be seized with a delicate forceps, raising it in a sense inversely to its natural curvature. This having been done, a small lamina of lead of a few millimeters thickness is to be inserted beneath the nail, and after folding it over the toe it is to be fastened there with a strip of plaster. In this manner the granulations being no longer in contact with the margin of the nail, the pain ceases and the sore heals more or less rapidly. During the whole of which time the apparatus should be frequently inspected, so that the lamina of lead may not become displaced. Besides this, it is necessary to scrape the nail every two or three days so as to keep it thin and flexible, until the skin returns to its natural state and can resist the pressure of the nail, and then the lead is removed.

Hebra treats ingrowing nail in the following manner: Cut some flakes of lint of the length of the lateral groove of the nail or a little longer. The lint is to be placed on the nail parallel to its groove: then with a flat probe introduce the lint, thread by thread, between the flesh and the nail. Thus the parts are separated with the little cushion of lint lying between. The sulcus is then to be filled with pledgets of lint, and finally, long narrow strips of adhesive plaster are to be applied, always from above the inflamed sulcus downward, in such a manner that the latter is still further removed from the margin of the nail. With such a dressing applied with sufficient care, there is no pain whatever: and the patient can in a short time put on his ordinary stocking and walk without trouble. After twenty-four hours the strips of adhesive plaster are to be removed, being previously softened in a bath of tepid water. This dressing is to be repeated daily, and in from two to four weeks it will be found that the toe is entirely well.

In those cases in which it is found that the nail is not abnormally implanted, and that it is the soft tissue only that grows in a vicious manner, I believe it will be well to remove the ulcerated tissues. This little operation, which may be performed without anaesthesia, deserves to be described. A double-edged bistoury held as a pen, is to be passed through the diseased tissues, taking care to graze the lateral margin of the nail where the disease exists. The tissues are then to be removed in such a manner as to expose the side of the nail which lies buried in the pulp. The wound should be washed with a solution of carbolic acid, and some lint placed on it like a cushion, which is firmly secured by a bandage, with some compression.

Eczema Unguale.

The treatment of ungual eczema is based on the use of alkalines or arsenicals, according to the fundamental nature of the disease, and hence alkalines in arthritismus and arsenic in herpeticismus. Emollients and ointments containing tar are the most useful topicals. It has seemed to me that occasional scraping of the exuberant nail has assisted greatly: but circumspection and prudence are to be employed lest the inflammation be increased.

Onychogryphosis.

The treatment of onychogryphosis consists in knowing how to avoid the causes which produce an irritation of the subungual derma. When the derma is not too much altered, the unguis substance is to be cut off with strong scissors or with a suitable saw. Ablation seems in general to be a palliative rather than a radical measure, since the causal element still remains, and the onychogryphosis recommences.

Onychomycosis.

The first indication in the treatment of both forms of onychomycosis is to destroy the fungus, placing the parasiticide in thorough contact with it. Bergh recommends thorough scraping of the nail and the application of compresses impregnated with carbolate solutions. Lint with benzin, creasote, turpentine, potassa, or sublimate serve as useful parasiticides. Sometimes the nail is normally reformed, but often it is reproduced deformed, or more or less defective, according to the extent of injury inflicted by the parasite.

THE PRIMARY LYMPHATIC RADICLES.

THE vessels comprising the lymphatic system derive their origin from "capilliculæ," whose calibre does not exceed $\frac{1}{1000}$ of a millimetre. These communicate freely with each other, forming, wherever such communications take place, proportionate enlargements, which may be compared to minute lakes, whence their name, *lacunæ*. The general aspect, therefore, of the primary lymphatic radicles is that of a network of capilliculæ and lacunæ. That this network so long escaped the notice of histologists is owing not only to its extreme minuteness, but also, and chiefly, to its perfect transparency. In order to render it visible, this latter condition must first of all be altered. This the author has accomplished by filling the capilliculæ with those low vegetable organisms now generally known as microbes, thus imparting to the vascular walls a light yellow tinge, sufficiently marked to bring them into distinct view. But these microbes reproduce themselves no less rapidly and abundantly in the plasma of the blood than in that of the lymph. Now it is evident that they can only serve to demonstrate the lymph-capillaries by being entirely excluded from the blood-capillaries, since, otherwise, their presence would render the two kinds of vessels entirely undistinguishable from each other. This exclusion is effected by injecting the blood-capillaries with an acidulated fluid in which microbes are unable to propagate. The result is that the blood-capillaries remain invisible, while the primary lymphatics are clearly revealed under the microscope in the minutest details, and in all their infinite varieties.

The question whether there is any communication between the lymphatic capillaries and those of the blood, is answered in the negative. The primary lymphatic vessels have been shown by careful experiments to be everywhere hermetically closed. The plasma of the blood enters them by means of simple transudation, or of capillary attraction, and almost in an unchanged condition.

The above-described network of lacunæ and capilliculæ consists of cavities whose walls exhibit no traces of endothelial cells, but are formed of a simple amorphous membrane. Beneath it is a collective network of more complex structure, having its membranous lining covered with a distinct, continuous layer of endothelial cells.

All the lymphatic vessels, of every degree, appear to be totally devoid of muscular fibres.—E. SAPPEY: *L'Union Médicale*, June 23, 1883.

THE TREATMENT OF SYPHILIS BY HYPODERMIC INJECTIONS OF AMMONIATED MERCURIAL PEPTONE.

1. The bichloride of mercury, associated with a dry peptone prepared according to the formula given by Delpech, is easy of administration and not painful, when used with the requisite precautions.

2. These injections do not expose the patient to local accidents, such as phlegmons, abscesses, ulcerations, even when they are practised upon syphilitics attacked with diabetes.

3. The therapeutic effects are remarkable: this treatment exercises upon syphilis and its diverse manifestations, an action much more energetic, much more rapid, and much more efficacious than that obtained by other methods of administration of mercury and its combinations. The numerous cases of grave syphilis cured by this medication constitute one of the brilliant proofs of this energy of action.

4. Salivation, mercurial stomatitis almost never happen, even when the sublimate is carried to the dose of ten milligrams, provided there exists no inflammation of the mouth or gums, no irritation produced by tobacco, alcohol, or bad condition of the teeth, etc.

5. The ordinary gastro-intestinal troubles of mercurial treatment are not observed in the treatment by the ammoniated mercurial peptone. This method also permits the general treatment of a constitutional or diathetic disease, pre-existing at the time of syphilitic contagion.

6. The hypodermic treatment dispenses with topical applications to syphilitic lesions: papules, mucous patches, etc., disappear without tincture of iodine or the nitrates.

7. The patients, in general, support quite well this kind of treatment, by reason of the local innocuity of the injections, and become habituated to it quite readily.—*Th. de Paris*, July, 1883.

STUDY OF SCIATIC BLENNORRHAGIA.

IN the course of blennorrhagia among men or women, there may develop a sciatic neuralgia which is, in the majority of cases, attributed to some other cause than the blennorrhagia itself.

The same is true of arthritis, hydrarthrosis, ophthalmia, and the other manifestations of blennorrhagic rheumatism: the urethral discharge alone is capable of producing them.

This relation is demonstrated by:

1. Sciatica and blennorrhagia co-exist too often in the same individual for this association to be referred to the hazard of chance.

2. Sciatica figures most commonly among the number of accidents due to urethral rheumatism.

3. It is observed to be redeveloped in successive attacks of urethral rheumatism.

4. In a series of rheumatisms of this order, it alternates at times with manifestations of the same nature, but of a different location.

5. It disappears by anti-blennorrhagic treatment.

6. It appears in a blennorrhagic patient with a group of symptoms which, in certain respects, differ from those of ordinary sciatica.—A. BRISSON; *Th. de Paris*, July, 1883.

INTERSTITIAL KERATITIS IN HEREDITARY AND ACQUIRED SYPHILIS.

1. INTERSTITIAL keratitis is most often a manifestation of late hereditary syphilis. It is an excellent diagnostic sign. When a patient suffering from interstitial keratitis presents a scrofulous appearance, one should not attach too much importance to this, but carefully search for the dental alterations, which are almost pathognomonic of syphilis ("Hutchinson's teeth"), deafness, bony lesions, cicatrices, etc.; the history of the parents, miscarriages of the mother, the mortality among the children, etc. Late hereditary syphilis often puts on the mark of scrofula.

2. This keratitis may be congenital.

3. Acquired syphilis sometimes appropriates this lesion. It may be placed among the secundo-tertiary accidents.

4. Rheumatism may also produce interstitial keratitis.

5. Interstitial keratitis may be vascularized or not, and complicated or not with iritis.

6. Iodide of potassium is the best resolvent of this infiltration of the cornea.—A. COUZON: *Th. de Paris*, July, 1883.

THE APHTHOUS VULVITIS OF CHILDREN.

1. APHTHOUS vulvitis is a well characterized disease. It is peculiar to little girls from two to five years of age. Rare in private practice; it is observed especially in hospitals.

2. Measles is the principal cause of this affection. It furnishes two-thirds of the cases.

3. Gangrene of the vulva has most frequently for its point of departure aphthous vulvitis.

4. The prognosis, which was unfavorable before the employment of the iodoform treatment, has become quite favorable since the introduction of this agent as a topical application.

5. The treatment consists in sprinkling the affected parts with iodoform powder, and keeping them separated with pledgets of lint. The internal administration of tonics is a useful adjuvant of local treatment.—ARSÈNE SARAZIN: *Th. de Paris*, July, 1883.

ECHINOCOCCUS AND URTICARIA.

THE patient had a large tumor in the epigastric region, forming a prominence on the right side. The introduction of an exploring needle at 11 A.M. was followed by an urticarial eruption, with fever which lasted for some hours; in the evening, a few patches of nettlerash were still visible in the immediate vicinity of the puncture. Vomiting took place at intervals for several days afterward, and each of these attacks was succeeded by a fresh crop of urticaria (*Berl. Klin. Woch.*, No. 30, 1881, and *Ann. de Dermat. et de Syphil.*, p. 597, Oct. 25, 1882). Monneret was among the first to describe these phenomena, and they formed the subject of a recent lecture by M. Féréol, at the Académie de Médecine.—*L'Union Médicale*, June, 1883.

PATHOLOGICAL ANATOMY OF GENERAL EXFOLIATIVE DERMATITIS.

THE conclusions arrived at by Erasmus Wilson, in his essay upon this disease, are as follows: 1st. Its lesions resemble those of psoriasis. 2d. It involves an

abnormally active growth of the superficial horny layers, together with structural changes in the other layers. 3d. There is partial infiltration of the derma depending upon the superficial vascular network. This infiltration is confined to the adjoining vascular tissues.—BROCQ; *Ann. de Dermat. et de Syphil.*, Oct., 1882.

SCROFULOUS UNGUAL DACTYLITIS AMONG CHILDREN.

1. THERE exists among scrofulous children a special variety of ungual dactylitis.

2. It is characterized especially by its slow progress, and is accompanied by the elimination of the nail and the formation of ungual fungosities probably of tuberculous nature.

3. It has been confounded and is often still confounded with perionychia and the dactylitis which is observed in syphilis.

4. The general treatment ought to be that of scrofula, but ordinarily this is not sufficient to complete the cure, and it is then necessary to remove the nail and carefully scrape the fungosities.—BRUIS: *Th. de Paris*, 1883.

Item.

AMERICAN DERMATOLOGICAL ASSOCIATION.—The Seventh Annual Meeting of the American Dermatological Association was held at Lake George, August 29, 30, and 31. At this meeting the following papers were read:

A Study of the Coincidence of Syphilitic and Non-Syphilitic Affections of the Skin, by Dr. Hyde.

General Exfoliative Dermatitis, by Dr. Graham.

Impetigo Contagiosa, by Dr. Stelwagon.

On the Value of a Lotion of Sulphide of Zinc in the Treatment of Lupus Erythematosus, by Dr. Duhring.

A Case of Multiple Cachectic Ulceration, by Dr. Atkinson.

The Pathogenesis of Drug Eruptions, by Dr. Morrow.

Experiments in the Use of Naphthol, by Dr. Van Harlingen.

A Trip to Tracadie, by Dr. Fox.

Changes Observed in the Non-ulcerating Tubercular Syphilide, by Dr. Taylor.

Report of a Case of Ainhum, with Microscopic Examination, by Dr. Duhring.

Malignant Papillary Dermatitis, by Dr. Sherwell.

A Peculiar Papular Eruption, by Dr. Hardaway.

A Case of Lymphangioma, by Dr. Graham.

Peculiar Appearance of the Initial Lesion of Syphilis at its Beginning, by Dr. Taylor.

Pseudo-Psoriasis of the Palms, by Dr. Sherwell.

Psoriasis Affecting the Palms, by Dr. Alexander.

Treatment of Acne, by Dr. Piffard.

The following officers were elected:

President—Dr. R. W. Taylor.

Vice-Presidents—Drs. A. Van Harlingen and J. E. Graham.

Secretary—Dr. W. T. Alexander.

Treasurer—Dr. G. H. Rohé.

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Original Communications.

PSEUDO-PSORIASIS OF THE PALMS.¹

BY

SAMUEL SHERWELL, M.D.,

Brooklyn, N. Y.

IN using the above title for this paper, I inferentially and necessarily include those lesions invading the structures anatomically analogous, the plantar surfaces.

In all discussions, which have come up sufficiently often, in the New York Dermatological Society, as to whether a psoriasis, pure and simple, ever occurs on the regions named, I have steadfastly maintained the negative, always, however, being in the minority, and having, as we all know, an immense amount of printed authority against my position. Still it is an opinion I cannot, consistently with my theories and clinical experience on the subject, give up; believing, as I do, that it (the psoriasis or rather pseudo-psoriasis in question), when present, or appearing to be so, arises always from the concomitance of a superimposed, or congenitally double diathesis; and that, when such eruption appears, clinically not to be differentiated from a frank psoriasis in these positions, it is to my mind entire proof of a syphilis, "larvata" it may be; or else, of an easily traceable dyscrasia of the same kind.

I have brought up this subject, hoping to hear from this talented body some discussion and some further expression of the reasons why these locations should be so generally exempt in a general psoriasis, whereas in late syphilis we have them so often; and to ask if the rarity of attack, as claimed in the one, and frequency in the other, as admitted, is

¹ Read at the meeting of the American Dermatological Association, August 30, 1883.

not *prima-facie* evidence as to the correctness of my own views on the subject. Probably less than one-half of one per cent of cases of psoriasis would be classed as having palmar or plantar complications; is it not probable, or at least as possible, as a matter of chance, that the diagnostician, capable however as he may be, has erred, and not the disease itself, as to its location? It seems most probable so to me, in consideration of the protean character of specific disease.

I repeat, gentlemen, I am here not to give, but to ask reasons for this elective affinity, which is curious, if nothing else; for I personally can see no good histological reason for the exemption I speak of; neither do I, for instance, in cases of herpes zoster. Now it has fallen to my share to see very many cases of herpes, and in some among which the backs of hands, and even fingers, were covered with characteristic eruption, but none such present on the *vola manus*; yet we are told, and know that the peripheral nerve terminations have that way of showing irritation of their trunks and centres. Where can we find such plentiful and typical distribution elsewhere as in these parts? So, in this case too, I must fall back on the doctrine of election.

I do not, however, lay much stress on this side issue, but merely give it as illustrative; for I look upon herpes rather as an *acnte* accidental than as a true chronic dyscrasia, and while I have not observed it so located, others may have; still it must certainly be rare, and would be, from its rarity, curious.

In conclusion, I would say that I believe a squamous eruption on palms (excluding eczema, etc.) resembling psoriasis always to have a syphilitic diathesis for its base, or one of its bases; and to be *prima-facie* evidence thereof. I do not think the decision of this question, however, if it can be decided, would make any great change in the general treatment, but I do believe that an eruption of this nature in this location should always lead intuitively to the employment of Donovan's, rather than Fowler's, solution; but even here again, the result of treatment would evidently not be diagnostic proof.

Not wishing to weary the Society, I offer only one and that a condensed history of a case, as proof of how readily the implantation of syphilis, on psoriatic ground, leads to the formation of these pseudo-psoriatic efflorescences on hands, etc. I could supplement it with many others, and have had two cases even in the present month, the history of one of which, whose case I saw on the 6th inst., would read like a duplicate of this I am about to give. Premising the fact that the squamous syphilide is invariably a late manifestation, that exudation into corium, dark and non-imbricated and not easily flaking scales are the universal rule, I give notes on

Mr. X., æt. thirty-five; dark complexion, short stature, robust, well-

nourished man, came to my office August 6, 1882, with well-marked Hunterian chancre on corona, result of an exposure in Paris about a fortnight previously. Was treated by me in orthodox manner; rapid healing of the initial lesion followed. On his first visit, it being warm, he had exposed some other portions of his body, on which were present typical psoriatic efflorescences, which, on further examination, were found equally typical as to site; on inquiry, learned that he had suffered from this eruption about eight years, and that since first invasion, he had never been altogether free, though, as is usual, a little less pronounced in summer. None of the eruption was visible outside the clothing line except, as is usual, a few insignificant patches around border of hairy scalp (frontal). No eruption had ever appeared on hands, either dorsal or palmar.

He left for his home in the West about middle of August; heard from him occasionally thereafter, but being a refractory patient, found out that he had discontinued treatment soon after the induration around site of sore had passed away. About five weeks from this time, he reappeared one morning at my office with distinctive roseola and some pharyngitis, and commencing mucous patches, and remained in town for about ten days, in which time, owing to obedience to treatment, those lesions all but disappeared; he then left for Paris again, and did not reappear till beginning of January, 1883, and then came in great alarm to show me his hands, on which, to use his own words, "the same eruption is now coming which I have only had on my body and limbs hitherto, and my nails are also affected." On examination of palmar surfaces, I found them to be affected apparently as stated; numbers of circular (about size of silver three-cent piece) patches with imbricated scaliness, easily detachable, and leaving below the smooth pellicle held to be so diagnostic of psoriasis, and with no more infiltration or exudation in the corium at their base than is to be found present in psoriasis; the nails were also flaking and cracking over the lunulæ, and to some short distance above, and in short the whole appearance being undistinguishable from an undoubted psoriatic eruption.

I set his mind at rest, enjoined absolute obedience to orders as to medicine and hygiene, gave him mixed treatment, and a few weeks thereafter was glad to have word that the eruptions most prejudicial to his comfort of mind had vanished, and that the psoriatic lesions over the rest of the body had greatly diminished. Becoming careless again, the eruption on the hands, etc., came back, and a few weeks since he again called; being put on same treatment, he again disappeared, and I have no doubt but that the manifestations of the disease also did so.

The only case I have ever seen which has "given me pause," was one shown last winter at a meeting of the New York Dermatological Society,

by Dr. Bulkley, in which it did seem as if a frank guttate psoriasis had invaded the whole or nearly all of the body and limbs, including the palmar surfaces. It occurred on the person of a girl about nineteen years old, moderately well nourished, and of fairly healthy appearance. In this case I am bound to say that objectively she gave no indication of a specific taint, beyond a moderately marked posterior cervical adenopathy; of subjective history it is always in these cases useless to speak, unless affirmatively. positively—from the simple appearance of this eruption on the hands my mind was positive as to some accident, congenital or otherwise.

LEPRA ANÆSTHETICA (*Mains-en-Griffe*).

BY

E. C. SEGUIN, M.D.

REPORTED BY

R. W. AMIDON, M.D.,

New York.

THE patient, a male, æt. 13, consulted me October 18, 1881. He was born of healthy parents in Cuba. An elder brother died, after an illness of three or four years, of the tubercular form of leprosy.

About four years ago, before the death of his brother, the patient was noticed to have a few colored rounded spots (not claret colored) on both thighs. There were no vesicles, but the mother thinks the spots were furfuraceous.

Three years ago pains, often severe, commenced in the little and ring fingers of the left hand, and extended up to the elbow. There was no swelling.

In the last year or fifteen months, contracture of fingers on ulnar side of left hand came on, which in the last eight months, became the seat of pains and deformity. In the last year also, some spots of reddish hue came on the lower part of the back near the sacrum—none on the face. Some conjunctivitis in the left eye. Great loss of sensibility in the hands; feet unaffected.

Examination reveals the patient to be a bright, active, well-grown boy of spare habit and nervous temperament. There are remains of an eruption on the anterior surface of the right thigh—a very faint patch a little glazed—showing papillæ abnormally.

On the sacro-lumbar region, and nowhere else, are several oval and rounded spots from one to five centimetres in diameter, reddish, shiny,

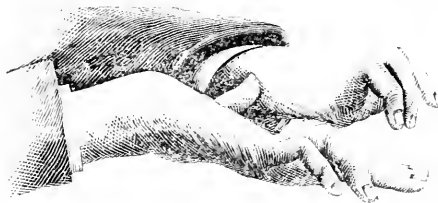
and distinctly less sensitive than the adjacent skin to pain and contact. These patches have neither scales nor moisture.

The left lower eyelid shows a diffused redness, and there is a localized blepharitis near the inner canthus.

Both hands, left much more, show the *main en griffe*. Opposition of the fingers and thumb nearly impossible. Interossei and eminences greatly wasted, as is also the ulnar side of the flexor surface of the left forearm. Skin of palms shiny and dry, and the growth of nails evidently retarded. One or two excoriations on the ulnar fingers. Great loss of sensibility to pain and touch in both hands, nearly complete in the ulnar distribution, and quite marked in the median finger (left especially), and slight, if at all, in index and thumb.

Careful palpation reveals a fusiform neuroma of each ulnar nerve about four centimetres above the inner condyle. Pressure on these enlargements causes sensation in the ulnar distributions.

Treatment advised was arsenic, cod-liver oil, and galvanism.



October 30th, electrical applications commenced, and conducted by Dr. Amidon, by whom the remaining notes were made:

A stable galvanic current, with the anode over the neuromata and the cathode in some indifferent location, or more commonly over the brachial plexus, was first given. Then the cathode was applied labile over both forearms and over all the intrinsic muscles of the hand.

On November 1st and 4th, Dr. Amidon made an electrical examination of the case. Galvanization of the left ulnar nerve at the elbow produces contractions in the ulnar group of the forearm only $\text{Ca cc} = \text{An cc}$. 40 cells. In the left flexor carpi ulnaris, $\text{Ca cc} > \text{An cc}$. In the interosseous muscles, $\text{An cc} > \text{Ca cc}$, and a total lack of faradic contractility. On the right side, much the same reactions existed.

On November 7th, the mother felt confident that the fingers of the patient had become much more supple.

By November 14th, there was very noticeable diminution in the size of the neuromata, while the arms and hands began to fill out, and the hands became much more flexible and useful.

After eight months of treatment, the patient was much better in every way, the neuromata almost disappearing, but the deformity and anæsthesia of the hands persisted.

THE TREATMENT OF ECZEMA.

BY

McCALL ANDERSON, M.D.

(Continued from page 403.)

ECZEMA of the nostrils (*eczema narium*) is not at all uncommon; it is very apt to follow attacks of scarlet fever, and often exists alone. There is no itching complained of in this affection, except at the point where the mucous membrane of the nostrils takes on the cutaneous character, the mucous membrane being, as a rule, unaffected by pruritus. The nose is often much increased in size. The secretion from the nostrils is likewise much augmented, becomes thick and purulent, and concretes into crusts, so as to impair the nasal respiration and cause the patient to sleep with the mouth open and to snore.

On removing the crusts, the mucous membrane is found to be thickened and congested, and ulcers form with considerable frequency. The patient feels the nose very much stuffed, and is thereby induced to remove the crusts which cover the ulceration. This has the effect of increasing the size of the sores, especially if the general health is not good, and cases are occasionally met with in which the ulceration has produced perforation of the cartilaginous septum; but I have never seen the bony septum attacked, nor any external deformity produced.

The diagnosis of *eczema* of the nostrils from *LUPUS* is sometimes difficult, especially in those rare cases of *eczema* in which perforation of the septum occurs, for *lupus* not unfrequently commences its ravages by perforating the cartilaginous septum. But if the disease is *lupoid* it is much more chronic; there is no itching at the orifices of the nostrils, and some of the characteristic papule of *lupus* are usually discovered on the skin of the nose or neighborhood, which, when present, at once point to the nature of the perforation. In *eczema* of the nostrils, on the other hand, there is often an *eczematous* rash externally, or the history of a past cutaneous *eczema*. And lastly, while *eczema* may occur in strumous persons, *lupus* is generally accompanied by other signs of struma, such as engorgement or suppuration of the glands at the side of the neck, caries, etc., or occurs in those with a hereditary tendency to strumous affections.

Syphilitic affections of the nostrils may likewise be mistaken for *eczema* of these parts. But in the former there is no itching at the junction of the mucous membrane with the skin; there are often syphilitic eruptions on the skin, or other symptoms of syphilis, such as alopecia, sore throat, glandular engorgements, nocturnal rheumatism, etc.; there

is often the history of a primary syphilitic sore, and, lastly, the affection yields to mercury and iodine.

I have very little to add with regard to treatment. Mildly stimulating ointments containing mercury, as white precipitate ointment diluted with four parts of lard, or very weak citrine ointment, are usually beneficial. Hebra recommends a strong solution of sulphate of zinc, which may, therefore, be tried in preference to solutions of potassa fusa; or when the eruption is located high up in the nasal cavity astringent suppositories¹ may be used, as recommended by Neumann, or Shoemaker's oleate of zinc powder may be tried in the form of snuff. Others are in the habit of using nitrate of silver either in solution or in the solid form, and benefit frequently accrues therefrom. The patient must be warned most particularly not to tear away the crusts, but to soften them carefully with oil, and after they come away to smear the ulcerated surface with one of the ointments just mentioned.

Eczema of the auricle (eczema aurium) is frequently observed, and may be limited to certain portions of it, or may implicate the whole ear. It not unfrequently happens that an eczematous rash is limited to the lobule, being called forth by the irritation of earrings. In other cases the disease is limited to those parts of the concha which are in the immediate vicinity of the meatus, in which case the latter is usually likewise the seat of eruption. In a third class of cases it is limited to the back of the auricle, to that part of it, namely, which lies in contact with the mastoid process (eczema intertrigo); indeed, in a large proportion of cases of eczema of the head this part is implicated.

When the whole auricle is invaded, the parts, in typical cases, are often excessively swollen, and the natural form of the ear is much distorted; and not only so, for the position of the ear is altered, being carried forward from the mastoid process, so that it projects from the head in a peculiar manner. The exudation, too, is often very abundant, and concretes into scabs, which fill up the hollows and depressions of the auricle, and may hang from the lobule like icicles.

Eczema of the external auditory passage (eczema meatús) occurs on both sides simultaneously in the great majority of cases, though sometimes only one ear is attacked, or one more than the other. In most instances the auricles are implicated, the disease commencing on the skin of these parts and gradually extending inwards, or *vice versa*; but the eruption is not infrequently limited to the meatus. As these cases are more frequently brought under the notice of the aural surgeon, the physician is apt to have erroneous notions as to their frequency.

¹℞ Zinci oxidi..... gr. ij.
Butyri cacao gr. xvi.
M. ft. suppositorium.

It may arise from the same causes which call forth eczema on other parts of the body, but the local causes specially operating are the introduction of pins, ear picks, and acrid substances into the meatus. The patient sometimes complains of a feeling of fullness in the ear; but the itching is the most annoying symptom, to allay which ingenious varieties of ear picks are frequently introduced, so as to scratch the parts—the finger-nails, which are employed for a like purpose on other parts of the body, being inadmissible. In this way the irritation is relieved for the moment, and the disease proportionately aggravated. The calibre of the meatus is narrowed, often so much so that the membrane of the tympanum cannot be distinctly seen, the amount of the narrowing being dependent upon the amount of infiltration of its walls. There is often exudation from the meatus at some stage of the disease, and the fluid which exudes is either purulent or serous, and sometimes so excessive as almost to soak the pillow at night. If the ear is not frequently washed out, the exudation has a very offensive odor. At other times the meatus is quite dry and scaly, and in connection with this condition I have frequently, with the aid of Brunton's speculum, observed the surface of the membrane of the tympanum to be dry and scaly also. Sometimes large quantities of epithelium are thrown off from the meatus, so as to block it up, and cerumen is often mixed up with the epithelial debris. The secretion from the ceruminous glands is, however, for the most part defective or arrested in this affection. The hearing power is often not much impaired, the amount of deafness depending upon the amount of infiltration of the walls of the canal, upon the quantity of epithelium and discharge accumulated in the meatus, and upon whether the drum and mucous membrane of the cavity of the tympanum are implicated or not. Sometimes the deafness is so great that the tick is only heard when the watch is close to the ear.

The patient often complains not only of deafness and itchiness, but also of a sense of uneasiness and fullness in the ears, of tinnitus and even giddiness. These last symptoms may arise from various causes, but in uncomplicated cases are doubtless due to the epithelial debris, etc., impinging upon the drum, thus driving the ossicles inward and inducing intra-auricular pressure; for, as is well known to those who have carefully studied the subject, pressure upon the internal ear produces symptoms analogous in many respects to those induced by pressure upon the brain. Not uncommonly, as the result, it may be, of the use of ear picks, etc., the case is complicated by the formation of furunculi, which are often very painful, owing to the narrowness of the canal in which they are formed.

The cure is occasionally a little tedious, as it is impossible to apply local remedies so satisfactorily to the meatus as to the skin; and strong local

applications must be used with caution, on account of the delicate structures at the bottom of the meatus. The ear must first be carefully syringed, so as to remove the exudation, epithelial debris, etc., and when the walls of the canal, instead of exuding, are scaly, a few drops of almond oil should be previously introduced, so as to soften the particles, and facilitate their subsequent removal. The relief and improvement of hearing following upon the use of the syringe is often so great as to astonish the patient who has allowed the exudation and particles of skin to collect in the ear for weeks or even months. After all the *effete* matter has thus been removed, the walls of the meatus may be painted with solutions of potassa fusa (commencing usually with a solution of ten grains in an ounce of water, but the strength must be proportioned to the severity of the disease). A small paint brush is dipped in the solution and gently stripped, so that it does not contain too much fluid, then insinuated into the meatus, to the extent of half an inch, and twisted round, so that the walls of the canal are entirely moistened by the fluid. This usually causes considerable smarting, which, however, subsides in a few minutes. If the action is severe, it may be checked at once by the injection of tepid water, for which purpose, it is well, previous to the operation, to fill a syringe with it, and hold it in readiness for use, if required. If a strong solution is used (*e. g.*, 3 i. to the $\frac{3}{4}$ i.), we must be very careful not to take up so much fluid with the brush that it drops upon the drum, as such applications which may be appropriate for the walls of the canal cannot be applied with impunity to the delicate structures at the bottom of the meatus. In cases where the drum participates in the disease, as usually happens, a weak solution (*e. g.*, potassa, gr. i. to $\frac{3}{4}$ i. of water) may be used as an injection night and morning, which is sufficiently strong to improve its diseased condition in most cases. A strong solution (3 i. to $\frac{3}{4}$ i. of water) may usually be painted on the walls of the meatus once or twice a week; but the more severe the affection, and the weaker the application, the oftener must it be repeated, and the more freely may it be used. In the intervals between the applications—which should never be trusted to the patient, if the solution is strong—we may direct him to syringe the ear twice daily with a weak solution of zinc sulphate and carbolic acid.¹ The beneficial effects of this treatment are sometimes very marked; the hearing often improves after a single application, the uneasiness in the ear subsides, the meatus becomes wider, and a large quantity of serous fluid exudes.

¹ R Acidi carbolici cryst.,

Zinci sulphatis.....āā gr. xij.

Glycerini... 3 iij.

Aquæ rosæad $\frac{3}{4}$ xij.

The following case illustrates what has just been stated:

"G. T., Esq., aged about forty-five, consulted me, January 10, 1862, for an affection of the ears, of two years' duration. He complained of tinnitus, uneasiness, and fulness in the ears, with severe itching, to allay which he was in the habit of using an ear-pick. Sometimes a profuse watery discharge, mingled with epithelial *débris*, came away from the ears; sometimes small scales only. He had latterly been troubled with deafness on the right side, the tick of the watch being heard at the distance of two inches and a quarter from the ear. An eczematous eruption was seen on the concha; the meatus was much narrowed, red, and scaly, and the membrana tympani dull and scaly, giving it a very peculiar aspect. On the left side the same symptoms existed, though in a less marked degree; but the hearing was good. The right membrane of the tympanum was relaxed and had fallen backwards somewhat, as the drum was seen to move outwards, and the hearing improved on forcing air into the cavity of the tympanum. To remove this condition, I touched the drum with a solution of nitrate of silver (gr. x. to $\frac{3}{4}$ i. of water), and on the 14th the relaxation was nearly gone, and the tick of the watch was heard at the distance of a foot. I now painted each meatus, after cleansing it with the syringe and warm water, with a solution of potassa fusa ($\frac{3}{4}$ i. to $\frac{3}{4}$ i. of water), in the manner above described. This was repeated on the 16th, and again upon the 18th, when the tick of the watch was heard at the distance of a yard from the right ear; the hearing in the left continued good; the itching, sense of fulness, and tinnitus were gone; the meatuses were wider and more natural in appearance, and the drums not so scaly. This application was repeated a good many times, and the canals washed out with tepid water twice daily in the intervals, with the most beneficial effect."¹

It will often be found that benefit accrues from the use of a solution of nitrate of silver, in the proportion of half a drachm or a drachm to the ounce of water, which may be painted every week over the meatus, in the same way as the potassa-fusa solutions. It occasionally happens, however, that such a solution acts more powerfully than is intended, and produces pain, swelling of the meatus, and other disagreeable symptoms; but these usually subside in a few days under soothing treatment, and improvement of the primary complaint is the common result.

As an instance of the good effects of this treatment, the case of a lady whom I saw in consultation with my colleague, Professor J. B. Cowan, may be mentioned. She had suffered for some time from an eczematous rash of each ear, which had extended to the meatus and membrana tympani. The eruption, when I first saw it, was red, infiltrated, dry, and scaly, and much itching was complained of. There was likewise a sense of fulness, as well as of itching in each meatus, and the drums participated (in the manner before indicated) in the eruption. The tick was heard when the watch was at the distance of one inch from the right ear,

¹ See "Cases Illustrative of Diseases of the Ear." By T. McCall Anderson, M.D. No. II. Glasgow Medical Journal, April, 1863.

but was only faintly audible when pressed *firmly* against the left. It was audible, though not very distinctly, on the temples. The ears were to be washed out night and morning with warm water, and each meatus to be painted every second day with a solution of nitrate of silver (3 ss. to the $\frac{5}{8}$ i. of water). A mixture containing oil of cade, rectified spirits, and a few grains of potassa fusa,¹ was to be rubbed firmly over the external eruption night and morning, and to be washed off with petroleum soap and water before each re-application.

This was on December 23, 1862. On January 6, the report was as follows: "Tick of the watch heard at the distance of eight inches from the ear on the right side, quarter of an inch on the left. Meatus more natural in appearance. External eruption nearly gone. Apply the lotion in the morning only, and at night rub a little citrine ointment over the parts. Paint each meatus with the nitrate-of-silver solution once every three days only."

On January 29, 1863, the external eruption had disappeared; the meatus and drums were comparatively healthy in appearance, all uneasiness was gone, and the watch was heard ticking at the distance of more than a yard from each ear. We now recommended a course of Fowler's solution, to prevent a relapse, if possible; the painting of each meatus once weekly with the solution and the use of citrine ointment externally once daily.

After the infiltration of the meatus is moderated or removed, much benefit is sometimes derived from injections of tar water or of a weak emulsion of liquor carbonis detergens with water,² or from painting the canal daily with the undiluted liquor or with a little melted citrine ointment, care being taken to use the syringe and warm water before each reapplication of the ointment. Or, in order to bring the salve into contact with the whole canal, and to dilate the passage when it is contracted, a tent of pressed sponge (or laminaria digitata) covered with charpie, and spread with the ointment, may be introduced.³ Leeches

¹ R Potassæ fusæ.....	gr. xv.
Olei cadini.....	$\frac{5}{8}$ i.
Alcoholis....	$\frac{5}{8}$ iss.
Olei citronellæ.....	$\frac{3}{4}$ i.

M.

² R Liquoris carbonis detergentis (Wright & Co.).....	$\frac{3}{4}$ i.
Aquæ destillatæ.....	$\frac{5}{8}$ vi.

M. Sig. Warm the emulsion, and use with the syringe twice daily. Let the strength of the emulsion be gradually increased till the symptoms yield, or till it begins to irritate the meatus.

³ "Handbook of Skin Diseases," by Dr. Isidor Neuman. Translated from the second German edition by Lucius D. Bulkley. M A., M.D. D. Appleton & Co., New York, 1872, p. 180.

have been resorted to for the removal of congestion, but they are rarely, if ever, required; purgatives, like leeches, produce a temporary alleviation of the complaint only, unless it depends upon digestive derangement; astringent injections, though useful, are inferior to solutions of nitrate of silver, potassa fusa, and the other remedies above referred to, and blisters are often employed, although I think very unnecessarily, to call forth a counter discharge, if the eczematous exudation is very profuse, and the occurrence of bad effects from its cessation is feared; indeed, the usual result of a blister in such cases is to produce an eczematous eruption at the part to which it is applied. In severe cases, such as the one just related, a carefully regulated course of constitutional treatment may be carried out with advantage.

The flexor surfaces of the joints (eczema artienlorum) are very favorite seats of eczema, being exactly the reverse of what is observed in psoriasis, in which the extensor surfaces, especially of the elbows and knees, are attacked by preference. In this situation, the natural furrows of the skin are specially apt to become the seat of fissures, and this, taken in connection with the loss of elasticity of the parts as a result of the eruption, often interferes with, and renders painful, the movement of the joints. The eruption is almost invariably symmetrical, and it is curious to observe, as has been pointed out by Hebra, that an affection of the fronts of the elbows generally coincides with an implication of the popliteal spaces, and disease of the front of the wrists with disease of the front of the ankles; but eczema of the inguinal regions does not, as one might suppose, usually coincide with eczema of the axillæ, but rather of the genital organs and neighboring parts.

Eczema often attacks *the hands* (eczema manuum) and *the feet* (eczema pedum), and is often limited to one or other of these parts. Sometimes one hand or foot is attacked, oftener both; and sometimes both hands and feet are implicated together, though usually in an unequal degree, the other portions of the body being spared. The hands suffer alone much oftener than the feet, being exposed to the air and to the action of all kinds of local irritants. Hence cooks, bakers, warehousemen, grocers, bricklayers, smiths, etc., are very subject to the disease, their hands being exposed to great heat, to the prolonged action of water, or to the irritation of sugar, lime, particles of heated iron.

Hebra has met with cases in which eczema occurred in women at each successive pregnancy, with such regularity, indeed, that they have been able to say that they were in the family-way from this sign alone.

Owing to the number of the joints and the constant movement of the parts, fissures form with exceeding frequency in eczema of the hands and feet, but especially of the former. Indeed, it is on the palms of the hands that one sees the most typical cases of the fissured variety of eczema (eczema rimosum).

The hands and feet are often affected with eczema occurring in small, scattered, circumscribed patches, which are frequently very obstinate.

When the vesicular form of eczema attacks the soles or palms, but especially the former, the vesicles remain long intact, and the serum, unable to escape externally, burrows beneath the skin. Many vesicles thus run together, and bullæ, often of large size, are occasionally formed. The eruption may then be mistaken for *pemphigus*; but in the former we are guided by the history of the formation of the bullæ, by the confluence of vesicles, by the small number of the bullæ (usually only one or two), by their occurring only where the cuticle is thick and resisting, and by the detection of vesicles around the edges of the bullæ, and of a fully-developed eczematous eruption in the neighborhood.

The disease is not unfrequently limited to the palms of the hands or soles of the feet (eczema palmare et plantare), attacks of the former being, however, the more frequent of the two. When so limited, the eruption often partakes of the characters of eczema rimosum throughout. The parts are then dry and itchy, the skin thickened, inelastic, and fissured, the fissures occupying the situations of the natural markings of the palm, and impeding greatly the opening and closing of the hand. In typical cases, the hand is maintained in a half-closed position, as in a case previously related. The eruption may implicate the whole palm or only a portion of its centre, and the diseased gradually shades off into the sound skin. It has no tendency to heal in the centre. It is a very generally received opinion that an eruption limited to the palms and soles is invariably syphilitic. This is not the case, however, although it may safely be affirmed that in this situation we have either to deal with syphilis, psoriasis, or eczema.

Syphilitic eruptions on the palms of the hands and soles of the feet may generally be distinguished with ease from eczema. I have already pointed out most of the symptoms which distinguish a syphilitic eruption from a non-syphilitic eczema; but, in addition, it may be remarked that a syphilitic eruption on the palm usually commences as a small spot near its centre, which gradually extends circumferentially, and heals in the centre so as to form at last a circle of eruption, with an abrupt and often elevated edge, inclosing more or less healthy skin. The eruption, besides, has often a somewhat coppery tint, is not itchy, and is removable by mercury and iodine alone. It must be observed, further, that this is often the only sign of syphilis which the patient exhibits at the time he is under observation.

It is not easy always to distinguish *psoriasis* of the palms and soles from eczema. In the former there is neither exudation nor development of vesicles, though these may be wanting in eczema, too. Again, in psoriasis the eruption is generally more distinctly circumscribed, the

edge of the eruption being abrupt though not elevated, and itching is not such a constant symptom. But the most important guide to the diagnosis of psoriasis in such cases is the discovery of patches of psoriasis upon the elbows or knees, or of a hereditary tendency to the disease, or of a history of recurring attacks in the spring. Sometimes, however, all these diagnostic points are absent, and a certain opinion is almost impossible.

We must beware of confounding eczema of the palms with that disease which specially attacks the hands, although it is not limited to these parts, and which has been so graphically described by Tilbury Fox under the name of dysidrosis (the cheiro-pompholyx of Hutchinson). This affection occurs specially in the subjects of nervous debility, and in persons who perspire freely, and is in the early stage unaccompanied by inflammation. Vesicles form, as the result of the distention of the ducts of the sudoriparous glands with sweat, and look like "small boiled sago grains" embedded in the skin. Their contents do not become turbid, but the vesicles often run together and may even form bullæ; they are accompanied by itching and burning heat, and in the later stages there may be much pain when they rupture, which they do tardily; they leave behind a "non-discharging, reddened, exposed derma," and there is no crusting, as is so often the case in eczema.¹

To avoid falling into the error of mistaking eczema of the hands for *scabies*, the reader must bear in mind what has been already stated under the general diagnosis of eczema; but I may call to recollection several important data, namely, that in *scabies* the eruption, except at the very commencement, is never limited to the hands; that we should be able to detect the furrows at least of the itch insect, if not the insect itself; and that we should inquire if there is any sign of the eruption being contagious—*scabies* being very contagious, while eczema is not.

When eczema occurs between the toes, it is often very troublesome, not only because these parts are in constant motion, but because they are in contact, and rub against one another; and because the perspiration is confined, decomposes, and acts as an irritant. Itching is very troublesome, and pain often complained of, owing to the presence of fissures. The cuticle is thickened; white, like that of a washerwoman's hand after a day's washing, and separates in large flakes. The secretion is often abundant and offensive.

With regard to the special treatment of eczema of the hands and feet, very little remains to be said. In these cases a rapid and brilliant result sometimes follows upon the use of vulcanized India-rubber gloves and stockings. When bullæ form they should be left intact, unless the pain

¹ "Skin Diseases; their Description, Pathology, Diagnosis and Treatment." By Tilbury Fox, M.D. Third edition, p. 476. Henry Renshaw: London, 1873.

and tension are great, when the serum may be allowed to escape by means of a small puncture.

If the eruption attacks the fingers or toes, and is complicated with painful fissures, it is advisable to commence the treatment by bandaging each finger or toe individually with narrow strips of rag spread with one of the soothing ointments already mentioned, and kept in position by gloves or stockings. The dressings must be changed night and morning and the loose epidermis and debris removed with firm friction, so that the new ointment may come into direct contact with the morbid surface, and in order that subsequent itching may be avoided. Often this treatment results in a complete cure, but if, after the fissures are healed, the eruption does not improve, some of the more stimulating applications already referred to may be tried, and I have occasionally found eczematous eruptions between the toes yield in a few days to lotions of carbolic acid, after other treatment had failed.

Mr. P. Beiersdorf, apothecary at Hamburg (22 Mühlenstrasse), has recently, on the suggestion of Dr. G. P. Unna, introduced a series of plasters, spread on muslin, the basis of which is gutta-percha combined with a great variety of drugs. These plasters are soft, pliable, and waterproof, and I have found some of them, especially oxide of zinc plaster (containing 55 per cent of oxide of zinc), lead and Peru plaster (30 per cent of the former and 17 per cent of the latter), of exceeding value in the treatment of cases such as those which are now being considered, although they are also very useful in eczema of the hands and arms, feet and legs, and when the eruption is situated at parts habitually in contact. The plaster used must be a soothing one if the eruption is acute; but if it is chronic, a stimulating one may be employed. It should be cut into narrow strips, and the parts firmly and smoothly bound with it. It may often be left on for days, and only changed when it gives signs of getting frayed or displaced or deteriorated; and if it is adhering firmly, the outside may be sponged with water before it is removed. I have sometimes seen a cure result from a single application of the *emplastrum zinci*. The only drawback to the plasters is their costliness, but when they come into more general use, as seems probable, it is to be hoped that they may be obtained at much less expense.

Eczema limited to the palms of the hands is sometimes very troublesome. The remarks already made with regard to the treatment of obstinate circumscribed eruptions are specially applicable to it; but the local stimulants there recommended, and, indeed, all other kinds of external applications, sometimes fail in yielding more than temporary relief. Mr. Malcolm Morris has recently advised in these cases the application of papaine, the partially purified extract obtained from the papaw tree, a remedy which was recommended at the International Congress in Lon-

don, 1881, as a solvent of diphtheritic false membrane, and which is used in the West Indies to soften tough meat. He uses a solution¹ containing borax with the view of checking fermentation and supplying the alkali required in order to obtain the full action of the drug. The parts are painted twice daily with this solution, and washed once daily with soap and water. The application only produces slight pricking and tingling sensations. It may happen in this, as in the other varieties of eczema of the hands, that there is some local source of irritation (as, for example, the pressure of the handle of the spade upon the palm), which is keeping up the disease, and which must be sought for and removed. As regards internal treatment, I am inclined to think that a course of tar or carbolic acid is as likely as one of arsenic to prove useful in such cases, although none of them can be confidently relied upon.

In *eczema of the legs* (*eczema crurale*) we must bear in mind the predisposing causes; the interruption to the circulation, caused by the use of tight garters; the distance of the parts from the heart; their usually dependent position, and the frequent occurrence of varicose veins, particularly in persons advanced in years. We must also recollect that the eruption is a frequent accompaniment of that thickening of the tissues and swelling of the leg which goes by the name of elephantiasis arabum, and which is favored by the causes just mentioned.

All these circumstances, by retarding the current of the circulation and keeping up congestion, lead to an increased deposit of pigment in the mucous layer of the epidermis, in consequence of which the eruption is apt to assume a coppery tint and to be mistaken for a syphilitic affection. They also account for the fact that eczema is very apt to assume its most aggravated forms on the leg, and that ulcers, often of great size, so usually complicate the affection (eczematous ulcers, as they are called). The development of eczematous eruptions on the leg is, however, often secondary to the formation of ulcers, being due to the use of fomentations, poultices, and irritating applications, with the view of healing them up. They may exhibit any form of ulceration, from the inflamed to the indolent, and must be treated according to their appearance upon general principles. An eczematous and ulcerated condition of the legs is not nearly so apt to occur in those who are walking as in those whose occupations necessitate their standing all day. "It is well known," says Bulkley,² "that the veins have valves directed towards the heart, which are especially large in

¹ ℞ Papainæ.....gr. xij.

Sodæ biboratis.....gr. v.

Aquæ destillatæ.....3 ij.

Solve.

² "Eczema and Its Management," by L. Duncan Bulkley, A.M., M.D., p. 235. Churchill: London, 1881.

the vessels of the lower extremities. These are of more service than simply to prevent the blood from returning when it has welled up from the capillaries. They are active elements of the circulation; they are, indeed, the valves belonging to a second, heart-like power which assists in propelling the blood, namely, the voluntary muscles of the limbs and trunks. Each time that the muscle contracts, as in walking, the blood is forced from it and from the flaccid veins which it surrounds, and as it cannot be crowded backwards because of the valves in the veins, the current is forced onward towards the heart. Now, when there is not the alternate contraction and relaxation of the muscles from constant use, but simply a constant strain, as in standing, the circulation loses just this impulse, and the veins, unable to stand the constant pressure unaided, become dilated, the valves are stretched open and cease to act, and all the consequences of the impeded circulation result."

In the treatment of eczema of the legs, it may occasionally be necessary to confine the patient to bed, or to keep him on the sofa, if it can be managed; otherwise cases will be encountered which resist all the recognized means of cure. A case of this kind occurs to me now, in which everything failed till I prevailed upon the patient to remain in bed for a week, in addition to the treatment previously followed out, at the end of which time the disease, which had resisted treatment for many weeks, had completely disappeared. But, as a rule, this should not be insisted on, nor, indeed, is it advisable; for it is as true of eczema as of ulcers of the leg, that cures thus effected are very apt to lose in permanency what they gain in rapidity.

The support of a bandage of some sort is generally indispensable, especially if the eruption occurs as a complication of varicose veins, or if the patient is much upon his feet. It may be worn by night as well as by day, if it is not uncomfortable, as, by giving continued support to the parts, it hastens the cure. And it is well-spent time to give the patient careful directions as to its use, and to teach him how to put it on. It should be firmly and equably applied, and taken off and readjusted at least night and morning, or oftener if it becomes loose and consequently ineffective. It may be of linen or flannel, and applied dry or soaked in one of the lotions previously alluded to, and it must be washed, ironed, and carefully rolled up before it is again used.

It is sometimes advisable to dip it in a solution of dextrin in boiling water, as Devergie recommended, or in a mixture of equal parts of melted stearine and rock paraffine, according to Startin's method,¹ so that, when it dries, it forms a hard case for the leg.

¹ "On Paraffo-Stearine, a Substitute for Starch, Plaster of Paris, and Such Like Substances, in Bandages and Splints." By James Startin, F.R.C.S., *British Medical Journal*, March 23, 1867.

If the eruption is not irritable, and if it is complicated with indolent ulcers, as so often happens, the firm application of straps of adhesive plaster about an inch wide and long enough go to once and a half round the limb in the form of a scultetus is often useful. It may be necessary, however, before applying the plaster, to cover the eruption with thin rags smeared with cold cream, fresh butter, or the like, as it is apt to irritate it. If the parts are irritable, straps of linen spread with one of the soothing ointments already mentioned, may be applied, which not only give support, but likewise tend to heal up the eruption. In this class of cases the most excellent results are often obtained from the application of bandages made of pure vulcanized India-rubber, as recommended by Dr. Martin, and therefore called Martin's bandages; or, if expense is no object, from the use of one of the plasters mentioned in connection with the treatment of eczema of the hands and feet.

With the exceptions mentioned, the treatment applicable to eczema of the legs does not differ from that of other parts. .

(To be concluded.)

Society Transactions.

NEW YORK DERMATOLOGICAL SOCIETY.

138TH REGULAR MEETING, SEPT. 25, 1883.

DR. P. A. MORROW, *President, in the Chair.*

PRESENTATION OF CASES.

DR. TAYLOR exhibited a

CASE OF POISONING FROM RHUS VENENATA.

The patient was the same that he had exhibited at the last meeting (this JOURNAL, July, p. 307) as a case of exfoliative dermatitis (see Plate). At that time he did not imagine that there could be any external cause for the dermatitis from which the patient suffered, but subsequent developments had now convinced him of his error. It had since been found that, in March last, the patient had freely handled poison sumach (*Rhus venenata*), and had soon afterwards developed dermatitis. He was sent to his home in the country to bring back some of the plant, and when he did so, the dried leaves were slightly rubbed over the first metacarpal interspace of his left hand. This was done on the eleventh of the present month (September). On the fifteenth he complained of itching and burning over the left deltoid muscle, on the thighs and genital organs. The conjunctivæ soon became reddened, and the entire skin was soon covered with large red blotches, resembling an erythema of a potash eruption, or a scarlatinal exanthem. The orderly who carried on the experiment rubbed some of the leaves on his own hand also, and was attacked two days later by rigors, itching, enlarged axillary



DERMATITIS FROM POISONING BY RHUS VENENATA.

glands, and a diffuse cellulitis of the hand and a portion of the arm, resulting in suppuration, and the formation of a small slough.

Before the experiment on the patient with the dried sumach leaves was made, his skin had become smooth, and, with the exception of the deep pigmentation on the thorax, abdomen, and face, a certain amount of buccal leukoplakia, and a lichenoid condition of the back, he was almost well, having gained greatly in weight and strength. He had taken the "mixed treatment" for a short time only, and had been treated mainly on the expectant plan.

He (Dr. Taylor) was now convinced that he could, with absolute certainty, eliminate all factors of an internal origin from the etiology of the dermatitis which was present in the case. The patient's emaciation and debility were extreme when he first came under observation, and the general desquamation was, next to that, the most marked feature in the case. In the second, experimentally produced attack, the exfoliation was very slight. The striking point of the case was that after an external irritation, great activity of the epidermic production, as manifested by the changes on the skin, nails, and the mucous membrane of the mouth, was brought about. Another interesting observation was the difference between the periods of incubation in the two cases, in one two days, in the other five.

DR. PIFFARD exhibited a

PHOTOGRAPH OF A CASE OF POISONING FROM RHUS TOXICODENDRON.

Showing the penis of a boy whom he had quite recently attended during an attack of poisoning from *Rhus toxicodendron*, exhibiting the extensive oedema



and deformity of the organ produced by this agent. He desired to call attention to the fact that, in a large proportion, perhaps a majority of cases of poisoning by *Rhus*, even where there has been no direct exposure of the penis, this organ is affected. This fact is susceptible of two explanations, either that the organ has

been infected by the transfer of the poisonous agent by the hands of the patient, or that the drug acts upon it after having been absorbed. The same occurrence has been frequently observed after the use of other agents, such as an ointment of tartar emetic, or a thapsia plaster, even when precautions have been taken to guard the genital organs against contact with them. It was an extremely interesting question whether the production of genital dermatitis in such cases was the result of transfer in spite of precautions, or was the manifestation of a predilection of the drugs in question for these parts.

As he saw more of these cases of rhus poisoning, he was more and more impressed with the profound nature of the disturbance. The fact that it so often relapses without a fresh exposure shows that its effects are not purely transitory. He had seen but two or three cases of poisoning from *R. venenata*, the *R. tox.* being much more common in this State. He had never seen a case of poisoning by the latter in which the eruption was so prolonged as in Dr. Taylor's patient. It might be that the action of the *Rhus tox.* is always shorter and less intense than that of the *Rhus venenata*.

DR. BULKLEY could not understand how such a chronic disturbance as was present in Dr. Taylor's case could be due simply to sumach poisoning. He was of the opinion that the patient had originally had an acute ichthyosis which lowered his vitality, or that that change in the system of the nature of which we are ignorant, which leads to the development of exfoliative dermatitis, or pityriasis rubra, had occurred.

DR. SHERWELL thought that the participation of the genital organs in the dermatitis in these cases was always due to direct transfer of the poison, the thinness of the skin of these organs rendering them unusually susceptible to irritation.

DR. DENSLOW said that he had recently seen two or three cases in which the mucous membrane of the mouth alone was affected, the patients having put twigs from the plant between their lips. Until a recent period he had not succeeded in relieving cases of rhus poisoning very soon, but having somewhere seen sassafras tea highly praised in the treatment of the affection, he had recommended it, and was surprised and gratified to find the patients recovering in two or three days. He had ordered an ounce of the bark of the root to be made into one pint of a tea, to be used both locally and internally.

DR. BRONSON stated that he was unable to understand how rhus poisoning could produce such profound and long-continued alterations, extending over a number of months, as had taken place in Dr. Taylor's patient. When the case was shown before, he thought that the sebaceous glands were largely involved in the production of the lesions present, and he was still of that opinion. He was now unable to decide whether the disease was originally simply a seborrhea or some affection of the epidermis proper. With regard to the involvement of the genitals in rhus poisoning, he thought there was nothing remarkable about that circumstance, since in ordinary acute eczema in other parts of the body, it is common for the disease to appear on the genitals also, the cutaneous irritation seeming to excite the nervous elements of the skin, and to cause an inflammatory outbreak in the most vulnerable parts.

DR. TAYLOR remarked that the fact that in his patient's first attack the palms of the hands and the soles of the feet presented great masses of thickened epidermis, as in psoriasis of those parts, showed that the disease was at least not one of the sebaceous glands alone.

DR. MORROW said that he had had this summer a case of poisoning from *Rhus tox.*, in which the eruption appeared on the hands and wrists. Before it appeared, he warned the patient not to handle his genital organs, but the eruption subsequently invaded them, notwithstanding the patient's care in this respect. It is a well-known fact that in some of the eruptions which occur in industrial pursuits, there is a peculiar tendency to localization on the genitals. This is also the case with eruptions from certain drugs, as quinine, arsenic, etc.

DR. FOX, alluding to the incubation of the disease, called attention to the published report of two cases in which a physician had unintentionally transferred

the poison to patients, in whom the eruption developed before it did in the physician himself.

DR. PIFFARD spoke of the great variations in the susceptibility of different persons to the poisonous effects of *Rhus tox.*, some members of a family being affected by it, while others of the same family could handle it with impunity. He had, not long ago, brought home some leaves of the plant and placed them in a botanist's drying-press. Two patients who happened to be in his office that day developed the characteristic eruption produced by the drug soon afterwards. It was possible, of course, that he might have conveyed the poison to them with his hands, but it might also be the case that the emanations from the specimen had caused the trouble.

Some years ago, he and a friend, while in the woods, had cut canes from a poison ivy vine. His friend placed his knife in his pocket, and soon afterwards the eruption appeared on his hands and on that portion of the thigh over which the knife had lain. He himself, not being susceptible, had had no trouble.

DR. BULKLEY exhibited a case of

ACUTE PAPULAR ERUPTION.

The patient, a man forty-three years old, developed, eighteen months ago, patches of acute lichen, the tissue infiltrated, with level summits, itchy, umbilicated. Two or three weeks ago (the first outbreak having much improved), he had another attack of bright-red discrete papules. In the older patches of eruption, especially on the anterior aspects of the arms, the lesions were larger and flatter, of a dusker color, and presented abundant evidences of oozing and scaling. They caused great annoyance from itching. There was also a patch over the left trochanter major, which had been there for twenty months. Over the patient's abdomen and legs were a few fading papules. Dr. Bulkley asked the opinion of the members as to the nature of the supratrochanteric patch.

DR. PIFFARD thought it a case of papular eczema, there being nothing about the patch on the hip which forbade that diagnosis.

DR. FOX thought the disease an acute, with remains of an old papular eczema.

DR. BULKLEY said that he recognized the eczematous nature of the lesions on the arms, but thought that when that element of the case should have disappeared, the lichen, which he believed to be the original disease, would once more predominate.

DR. ROBINSON asked the opinion of the members as to the increase in size of the individual lesions of lichen planus. Wilson had said that the papules do not enlarge, the patches being formed by the development of new papules. Neumann stated that the papules themselves formed patches by enlarging peripherically.

DR. TAYLOR was of the opinion that the patches were formed both by aggregation and enlargement of the papules.

DR. BRONSON believed that the papules did enlarge. They certainly increased in elevation above the level of the skin, and it seems reasonable to believe that they also increase peripherically.

DR. PIFFARD said that the papules of lichen varied in size, but never grew larger than two or three millimetres in diameter. He had found that umbilicated papules in the disease never grew large.

DR. KEYES spoke of the first case of this disease that he ever saw, in which a few flat, livid, umbilicated papules appeared on the back of the hand. He treated them with various irritating applications, which caused them to disappear, leaving cicatrices behind. They subsequently reappeared. In this case the papules certainly enlarged peripherically, attaining the size of a grain of rice. He also alluded to a case in which confluent lichen planus lesions covered the palms and soles, the backs of the hands and feet being free.

DR. BULKLEY inquired if any of the members had ever seen an eruption from iodoform. He described a case in which an ointment of this drug had been applied to an epithelioma of the face, and had excited an erythematous dermatitis of the surrounding parts.

DR. TAYLOR spoke of a case of ulcerating gumma of the leg, in which erysipelas followed the application of iodoform. After the erysipelas passed off, the gumma was found to have disappeared.

Correspondence.

THE OLEATE OF COPPER AND THE TREATMENT OF FRECKLES.

To the Editors of the Journal of Cutaneous and Venereal Diseases.

GENTLEMEN:—In reply to the recent letter of Dr. Borchheim, I would state that the oleate-of-copper ointment, like all other remedies, is not infallible, and while in many cases it has served me well in removing freckles, in some it has failed. As I have found the oleate-of-copper ointment not always certain in its action on freckles, I have never laid great stress upon it as a remedy to remove them, omitting this effect entirely in writing my paper on the Oleates in Skin Diseases, and only suggested it in an incidental manner, in reply to a query made as to a remedy for freckles, by a reader of the *Medical Bulletin*. The unfortunate results that followed the use of the oleate-of-copper ointment in Dr. B.'s practice may have been due either to a predisposition in those persons to furuncles, in which event almost any stimulating application would have brought about the same result, or the oleate of copper, as I will show farther on, may not have been properly prepared. I am inclined to the latter view, as no furuncles, either in my own or in the hands of others who have largely used the ointment of the oleate of copper, have ever followed. To ascertain this, I addressed a brief note to a number of physicians who, to my knowledge, had used it in their practice, asking them for their results with the oleate-of-copper ointment, and of any untoward effect or furuncular eruptions following its use. I give a few of the replies received, in brief, as follows, withholding a number, all to the same effect, not one confirming Dr. B.'s experience.¹

To show in which way the oleate of copper, as well as all the oleates, may be rendered, not alone not serviceable, but absolutely injurious, I would say that, when I stated, in my article on the oleates, that they should be made by the decomposition of sodium oleate with a solution of the salt of the desired base, I understood, of course, that the sodium oleate should be made of a good oleic acid. The U. S. Pharmacopœia, in its last edition, has adopted oleic acid amongst its officinal articles, and the description of it applies to an oleic acid which can safely be used for making the oleates such as I proposed. The oleic acid, generally in the market, and, on account of its low price, kept by most druggists, and offered by some of our manufacturing chemists, more or less purified, is nothing more than the red oil of the candle-makers, a very impure oleic acid, containing admixtures and contaminations which can be only removed by a tedious process, more so and at greater expense than the direct process of making a good and sufficiently pure oleic acid, answering the test of the U. S. Pharmacopœia, from the oil of sweet almonds. The oleic acid obtained as a by-product in the candle manufacture contains considerable stearic acid, its least objectionable admixture, but one which will render oleates made from it less diffusible. It contains besides, in consequence of being overheated in the process of its manufacture, various

¹ [Dr. Shoemaker incloses copies of letters from Drs. O'Hara, Blackwood, Snowden, Fricke, Fenton, McClellan, Prall, Herr, Welr, and Rosenthal. These letters are to the effect that the writers have used the oleate-of-copper ointment with benefit in freckles and other affections, and without the production of furuncles, or any other untoward effect.—Eds.]

volatile acids, hydrocarbons, sebacic acid, and, above all, oxyoleic acid, which is well known by giving fats their rancid odor and character when formed therein. Pure oleic acid even absorbs some oxygen from the atmosphere under ordinary circumstances, forming oxyoleic acid, but, when heated, does so in a very large degree. The red oil, or oleic acid of commerce, in being separated from its glycerin base, is exposed to a high heat, and is thus changed largely into oxyoleic acid, with all its characteristic irritant properties and odor.

The most of the oleates which have been shown to us by manufacturers who were desirous of making them according to the formulas given in my paper had, by appearance and odor, evidently been made with the common oleic acid, and were, along with those not even properly decomposed or purified, well calculated to do more harm than good, and prove probably irritative and productive of eruptions and furuncles. The oleates and the ointments thereof used by me and most, if not all, of the physicians who kindly gave me their notes were from the laboratory of Dr. L. Wolff, of this city, the chemist to whom we are indebted for the development of this class of oleates. They are by him obtained either by the decomposition of sodium oleopalmitate, freshly prepared from pure oil of sweet almonds, as oleopalmitates, or pure oleates from sodium oleate, made of pure oleic acid, derived from fresh oil of sweet almonds, and freed from palmitic acid. Such an oleic acid answers the description given of it in the U. S. Pharmacopœia and should be the only kind used. We feel sure that no unpleasant effects will occur with such oleates, if properly and judiciously used. That the price of the oleates is slightly advanced by making them of pure material is of no importance when we consider the small quantities thereof necessary in the treatment of skin and other affections. Respectfully,

JOHN V. SHOEMAKER, M.D.

PHILADELPHIA.
Sept., 1883.

CONTAGION OF LEPROSY.

To the Editors of the Journal of Cutaneous and Venereal Diseases :

Reading the recent article on Leprosy, in the July issue of your journal, and thinking the history of the following case will be of interest to your readers, I respectfully submit the same for their consideration :

J. S. H., aged twenty-three, residing in Brooklyn, contracted leprosy in Puerto Cabello, Venezuela, fourteen years ago, and came under my observation in 1878. The eruption first appeared on the face and extremities, and is of a macular and tubercular character, the former predominating.

He has had frequent attacks of fever peculiar to leprosy, and ulnar nerves are much thickened. At present he is thinner and has œdema of feet. His appetite is voracious at times. The history is as follows : A lady in South America was taken sick with this disease, and one of the present patient's aunts called frequently to see her. Before the death of the said lady referred to, the aunt contracted the same disease, which, so far as known, never previously existed in the family. The aunt used to carry the patient (J. S. H.) and was with him considerably.

Dr. E. L. Keyes, of New York, and Dr. S. Sherwell, of Brooklyn, have seen the patient.

Respectfully,

A. COSTALES, M.D.

BROOKLYN, N. Y.,
Sept., 1883.

Selections.

THE NATURE OF PURPURA.

It is generally agreed that the nosological position of purpura is unsatisfactory. There is a want of uniformity of view as to its nature, and a tendency to regard it as inexplicable. In some cases it appears to be only one of several symptoms expressive of some constitutional condition—and hence is called symptomatic purpura. In others it seems to arise spontaneously in persons in whom we can find no other serious derangement of health—and therefore is known as essential or idiopathic purpura.

Are there sufficient grounds for reserving this latter independent position for the cases of purpura, which, up to the present time, we cannot relegate definitely to some antecedent or known factor?

Within the last few years we have learned to trace many cases of purpura to their proper causes. Thus, we recognize it as occasionally an expression of syphilis, at other times as connected with idiopathic anæmia, or with anæmia lymphatica; we know, too, that it may be a manifestation of scurvy, or may be due to the administration of some drug, as chloral or iodide of potassium. Each of these kinds of purpura was once included under the common head of idiopathic purpura, and each, as its true nature became known, has been removed from that category. Thus, the group of disorders comprehended under this term tends to undergo dissolution, and is clearly one shut off from the remaining cases of purpura by the veil of ignorance.

In support of this position I would ask: Are there any pathological changes peculiar to, or characteristic of, purpura, which connect all cases by such a tie as to give them a close relationship, however dissimilar some of their features?

If we review what is known of the pathology of purpura, we shall find, as to *the condition of the blood*, that the great alterations found in the course of severe and often fatal cases indicate the consequences rather than the causes of the hemorrhages. Again, we may have purpura without anæmia, and anæmia without purpura: so that anæmia cannot be regarded as an essential element in purpura. In the vast majority of cases there is no leucocytosis. Deficiency in fibrin, or alteration in its quality, is certainly not the property of the blood on which hemorrhage always depends. We know that in some forms of purpura there is some constituent present which does not exist in ordinary circumstances, or, if natural, is present in excess; but how this acts in bringing about the hemorrhage we are in ignorance.

Next as to the *blood-vessels*. The cases in which changes have been found in the vessels must, I think, be regarded as too inconstant to throw a light on the nature of the mechanism of purpura.

While I attach much importance to the influence of the *nervous system* in producing hemorrhage, we witness the occurrence of purpura under conditions when there is no reason to refer it to this cause.

As regards gross changes in the various organs, or wide-spread microscopical changes in tissues, I think all will agree that none are constant or peculiar to purpura.

So, I take it that, whilst there are proved or probable alterations in the blood, in the blood-vessels, and in the regulating nervous mechanism, in certain cases,

no one of these is sufficiently constant to unite all forms of purpura in such a way that we can regard them as different varieties only of one common process. Neither is there any etiological factor common to them. Hence we cannot assign to purpura the position of a clinical entity.

Next, it may be asked : Is the hemorrhage that is the one characteristic of purpura an isolated phenomenon, or do we not see hemorrhage associated with various other morbid processes going on in the skin and elsewhere? Does the occasional occurrence of hemorrhage under these conditions throw any light on the immediate causation of the purpuric extravasations? Is the same element that sometimes gives the hemorrhagic character to the eruptions of herpes, pemphigus, erythema, etc., intensified in cases of so-called idiopathic purpura to such a degree that it obscures the others, and appears to constitute the main or sole phenomenon? The point is a difficult one. It may be that, given a neuritis, it is only a question of constitutional tendency, or of a temporary quantity of blood, that determines whether the cutaneous expression is a crop of herpes or a blotch of purpura. But it must be admitted that, in many cases that we closely watch, we cannot observe any local condition preceding the first appearance of bleeding into the skin.

It appears to me, then, that we can no longer regard purpura as a disease, but must look upon it in all cases as a *symptom*, not of one, but of various morbid states.

Inherited or acquired tendency should also be taken into account, in connection with the determining causes of this condition. Some cases of purpura may be the beginning of hemorrhagic diathesis, which, circumstances favoring, may be transmitted in an intensified degree to the offspring; or, circumstances disfavoring, may die out at once or later in the individual affected. A person may be the first or last link in a transmitted tendency to bleed, a tendency which might never have borne fruit but for some quasi-accidental circumstance.

If we agree to regard purpura purely as a symptom, it is still convenient to endeavor to classify the conditions under which it occurs. I would suggest the following as a useful arrangement :

1, Vascular purpura ; 2, toxic purpura ; 3, mechanical purpura ; 4, neurotic purpura.

Under the head of vascular purpura, I would place all cases in which there is some known or supposed primary blood-disorder, so that this group would include the specific blood diseases; diseases in which the blood-disorder seems primary or most important, as profound anæmia, leucocythæmia; conditions in which some constituents or constituent of the blood is wanting, as scurvy ; and conditions in which some constituent is present in excess, or superadded, as bile, urinary constituents, etc.

In the category of toxic purpura (drug-purpura), I would place all cases in which the purpura arises from adventitious matters entering the system, such as phosphorus, mercury, mineral acids, salicylic acid, quinine, iodides, venom. We do not know the exact mechanism by which purpura is brought about in this group; but it is clearly advantageous, clinically, to keep them apart, though logically they may be said to belong to the hæmic group.

Under the third variety, purpura from mechanical causes, we should place the cases of purpura arising in connection with heart-disease, a feeble circulation, from thrombosis of venous trunks, and, probably, senile purpura.

Into the last category, purpura of nervous origin, would fall the cases in which the nervous system is primarily at fault, and thus it would include cases of

tabetic purpura, purpura in connection with neuralgia and with disease of the nervous centres, purpura urticans, and neurotic eruptions (as herpes) becoming hemorrhagic.—STEPHEN MACKENZIE; *Brit. Med. Journ.*, Sept. 1, 1883.

THE TREATMENT OF SYPHILIS IN CHILDREN AT THE BREAST.

THE difficulties experienced in adapting specific medication to the case of very young infants, long ago suggested the inquiry whether the indicated remedies, especially iodide of potassium, might not be advantageously administered to this class of patients through the medium of the mother's or nurse's milk.

It was ascertained by the experiments of Labourdette and Dumesnil upon a large number of domestic animals, that when iodine was taken internally, about 25 per cent of it entered into combination with the milk, while the remainder passed off with the urine and feces. Subsequent investigators found that within two hours after the administration of iodide of potassium to a human female, her milk gave clear evidence of containing iodine; and one of them observed that a child whose mother had taken the same dose daily for a considerable period, became severely affected with the coryza and acne-eruption characteristic of the drug.

More recently, it has been maintained that the effect of iodide of potassium is to lessen the secretion of milk, while the proportion of iodine in the latter constantly increases during the employment of the remedy.

Notwithstanding these somewhat discouraging statements, the author was induced, by his sense of the practical importance of the question involved, as well as by reports which have been published of successful results from the use of iodized breast-milk, to submit this method of treatment to a careful test in the university polyclinic at Prague.

Four pretty severe syphilitic cases, in children aged, respectively, ten weeks, four months, eight days, and nine weeks, were the subjects of this experiment. All were out-door patients, whose parents belonged to the working-classes.

Their symptoms were of the usual kind—eruptions on different parts, ulcers and rhagades of the nose and lips, troublesome coryza, etc. Two of the cases, moreover, presented serious complications, in the shape of intestinal catarrh and stomatitis.

The only internal remedy employed was iodide of potassium, two grains¹ of which were given to each of the mothers daily, without interruption, during periods varying respectively from fourteen days to eight weeks.

In every instance a complete cure was indisputably effected—either by the time the medicine was discontinued, or very shortly afterwards—no traces of the disease being left beyond a more or less pronounced discoloration of the affected integument.

The apprehended effect of the iodide in lessening the secretion of milk was not perceptible in either of the four cases. If any slight diminution actually took place, it certainly did not interfere with the success of the treatment.

In conclusion, the author recommends further trial of this method on a more extended scale.—FERD. LINK; *Prager Med. Wochens.*, Aug. 8, 1883.

THE SITUATION OF THE MICROBES IN VARIOLA, VACCINIA, AND ERYSIPELAS.

THIS communication was rendered especially interesting by the tissue prepa-

¹ So in the original; we suspect that two grams, not grains, was intended.—Eds.

rations which accompanied it, and which demonstrated with great clearness the forms and localities of the objects referred to.

In the *variolous* specimens, the mucous layer of the epidermis was found transformed into a multitude of small alveolar cavities, partially filled with migratory cells, swimming in a fluid which sometimes presented threads of fibrin. These cavities contained the micro-organisms of small-pox, very clearly brought out by the contrasted colors employed. They were somewhat unequal in size, but very small (about 3-10ths of a millimetre in diameter), of rounded form, and either solitary or aggregated. In addition to these, numerous small granular elements were visible, probably the remains of nuclei.

The papillæ were always greatly altered in the vicinity of the pustule, their tissue was always more or less infiltrated with small round cells, and they sent forth irregular prolongations into the mucous layer; in these prolongations, and in the papillary tissue, long rows of microbes were detected, which are probably also present in the lymphatics of the papillæ, from which they penetrate into the cells of the mucous layer, and into the areolar cavities of which it is composed.

The *vaccine* pustules showed the same lesions and the same organisms, similarly arranged within the cavities of the mucous layer.

On the mucous surface of the *larynx*, the variolous eruption, when well marked, is accompanied by the formation of a fibrinous false membrane. Throughout this membrane, which contained a few migratory cells, the microbes were very numerous.

The epithelial layer immediately beneath the false membrane disclosed cells, or small vesicles, frequently containing micro-organisms.

Erysipelas.—The etiology of this disease has been completely made out by M. Fehleisen, who is reported to have successfully inoculated a human subject.

In the present investigation, transverse sections of the lymphatic trunks at the base of the papillæ revealed lymphatic cells and chains of small micrococci, consisting of rounded grains placed end to end, and having a diameter of about 6-100ths of a micra-millimetre. Deeper down in the derma, and between the bundles of connective tissue, similar groups of organisms were observed, and also in the adipose cellular tissue. Microbes were likewise discovered in the blood-vessels. They were present in considerable numbers between the inner sheath of the hair follicles and the space comprised between the latter and the roots of the hairs.

In brief, the erysipelatous inflammation of the skin, caused by the specific micro-organism, appears to follow upon the entrance of the latter into the lymphatic ducts.—CORNIL; *La Tribune Méd.*, Sept. 9, 1883.

THE VALUE OF EXPERIMENTAL AUTO-INOCULATIONS IN SYPHILOGRAPHY.

MUCH has been written about inoculations as a means of diagnosis in syphilis, and the law has been enunciated and pretty generally accepted that the simple soft venereal ulcer is auto-inoculable, while the hard, Hunterian, initial lesion of syphilis is not re-inoculable upon him who carries it; that it is not auto-inoculable. This law our author denies as a general proposition, and says: In some cases of soft ulcer we may be able to make use of inoculation as a test for diagnosis, but in most cases we cannot, and we should found our diagnosis upon other tests than that of the lancet puncture.

He bases the above opinion upon clinical facts and upon general pathology. The clinical facts are that the hard ulcer in a certain period of its course may be

auto-inoculable, reproducing upon the point of inoculation an exact copy of itself. Further, from this hard ulcer being irritated, some observers have obtained products of ulceration which being inoculated give lesions like the soft ulcer. And not only that, but he has observed many other peculiarities in the effect of inoculation, differing as much as the syphilitic or non-syphilitic subjects themselves differed in constitution and development.

General pathology, he says, shows how a chronic infection, such as syphilis, at first a local disease, may become constitutional. He points out how, often, purulent inoculation takes place which spreads to the neighboring lymphatic ganglia with the production of a series of abscesses, but without general or constitutional infection. He thinks that the soft sore may be taken from the domain of syphilography and relegated to general surgery, being placed in the category of purulent infection. The genital organs are predisposed to all forms of ulceration on account of the lacerability of the mucous membrane, the ready decomposition of their secretions, the notable vascularity, and relative high temperature of the parts. Now, he asks, is it extraordinary to think that this circumscribed process of ulceration may have preceded or accompanied, and masked the syphilitic erosion, when the local conditions which we find in the sick man are precisely those of a soft ulcer, and the general condition that of an incipient syphilitic process? As then it is possible in some cases to obtain a soft ulcer by auto-inoculating the products of a hard ulcer, this means of diagnosis is not to be depended upon.—CAMPANA: *Giornale Italiano del. Mal. Veneree e del. Pelle*, 1883, Fas. ii., March-April.

ON THE APPLICATION OF MEDICINAL SUBSTANCES TO THE SKIN IN THIN, FIRMLY-ADHERENT LAYERS.

In the local treatment of cutaneous diseases, success must mainly depend upon the attainment of the following objects:

(a) Exclusion of atmospheric air from the diseased surfaces, so far as contact with it may be deemed hurtful.

(b) Removal of secondary morbid products (*e. g.*, scabs, whose roughened under surface usually irritates the contiguous membrane, or scales, which interfere with the direct application of remedies to recently formed cutaneous layers), and, as far as possible, prevention of their renewal.

(c) Restriction of the morbid secretory processes which contribute to the above-mentioned formations—whether the secreted fluids be serous or purulent, and mingled or not with perspiration, blood, or sebum.

(d) Insuring the direct action, to the precise extent required, of certain medicinal substances upon the affected parts, and upon those parts only.

The means at our command for accomplishing these ends collectively, both in acute and chronic affections, have been principally applied in the various shapes of *plasters, ointments*, ethereal and alcoholic solutions, *to be laid on with a brush*, and, finally, *powders for sprinkling*.

Each of these has been found more or less objectionable, either as involving complicated or inconvenient processes or manipulations, or as aggravating symptoms they were intended to relieve; and, in consequence, the efforts of many leading dermatologists, both in Germany and other countries, have been directed, of late years, to the discovery of improved methods.

As a result, the local treatment of chronic cutaneous disorders has been especially improved by the addition of salicylic acid to the list of remedies, followed

by that of goa powder, chrysarobin, of pyrogallie acid (*Jarisch*), and of naphthol (*Kaposi* and *Ludwig*).

All these agents have shown themselves valuable in various ways; they are used most frequently in the form of powder or of ointment; but also in solution, or in a state of liquid suspension, when they are generally applied with a brush.

Some of the ointments and tinctures are apt to produce severe irritation in surrounding healthy parts. This is particularly the case with chrysarobin ointment, which is so exceedingly serviceable in the treatment of psoriasis; and sundry non-oleaginous substances have therefore been recommended as vehicles for that remedy.

Fox and Sesemann make use of collodion.

Pick recommends a combination of chrysarobin with gelatin in various proportions, over which a coating of glycerin is afterwards applied.

Chrysarobin "plaster-muslins" are proposed by Unna, who has recently devised a modification of Pick's method, which consists in blending the glycerin directly with the gelatin compound, instead of merely painting it over the latter.

Pick's "gelatin mixtures," which have been thoroughly tested by my assistant, Dr. Kohn, constitute undoubtedly a very superior excipient for the salts of chrysarobin.

I will now proceed to explain some of the causes which have interfered with the usefulness of this last-named agent, and which I propose to obviate by combining it with another substance instead of with gelatin.

As a vehicle for chrysarobin, I employ an artificial cuticle made by dissolving one part of purified gutta percha in ten parts of chloroform. This forms an excellent medium for fixing the application, as it adheres firmly and without alteration for two three days, or even longer. On comparing it with gelatinous excipients, the latter are seen to possess the following disadvantages:

1. They are liable to be rubbed off by contact with the limbs or clothing, and hence usually necessitate one or two renewals of the application.

2. The gutta percha compound forms a thinner and more delicate cuticle than either collodion or gelatin, producing neither tension nor pain.

3. Its neutral character adapts it as a protective investment, to parts however sensitive. Prepared as above, it has never given rise to irritative symptoms either in children or adults, even when painted over large surfaces.

4. It exerts a more equable pressure than gelatin, the flexible, elastic gutta percha adapting itself better to uneven surfaces; gelatin forms a brittle coating, so that an addition of glycerin is needed to render it sufficiently pliant, and prevent it from contracting too much when dried—especially when joints are to be covered.

5. It is far more convenient of application than gelatin. The solution can be quickly prepared and painted over extensive surfaces in a short time. As chloroform evaporates slowly, and gutta percha loses its flexibility only by degrees, the compound can be rubbed in, to some extent, before it has quite hardened upon the skin. In this way we are enabled to break down and remove any remaining scales or scaly debris, so that the chrysarobin may take effect upon denuded and bleeding eruptive surfaces. Gelatin, moreover, has to be softened by heating before it is fit for use; nor can it then be applied immediately without causing too much pain. On the other hand, if we wait for it to cool, the greater part of what is taken up by the brush becomes hard, and the rest has to be laid on in an awkward and uneven manner. This too rapid hardening, in short, is a

source of so many embarrassments that gelatin must be pronounced unsuited to the object in view.

6. The gutta-percha solution is durable; while gelatin, even with the addition of salicylic acid, easily becomes mouldy.

7. The former is far cheaper than any other vehicle that can be employed, because its preparation is so much less troublesome.

The manner of using chrysarobin with the gutta percha compound in the treatment of psoriasis, is as follows:

After removing most of the scales by a single bath of soap-suds, the ten per-cent solution is applied with a thin, short brush, and rubbed in, all over the effected parts. The application is repeated every day, if the disease has not spread far, or every two or three days, if it is of greater extent, and is preceded by baths of soap and water, or by local washings with the same, according to the amount of desquamation. Even after the first or second application many spots will be considerably flattened, and scaly only on their edges. From two to twelve applications, according to the extent and severity of the disease, will generally effect the disappearance of the infiltration and desquamation, leaving in their stead white spots, bordered with red or purplish-brown.

In some cases of a milder character, a daily application merely, without either baths or washings, will suffice to remove all evidences of psoriasis in from two days to a week.

To exemplify the best mode of carrying out this treatment, in accordance with the extent and locality of the disease (psoriasis), brief reports of several cases are given, as copied from the clinical records of Dr. Kohn. Almost all of them, after describing a short series of baths and applications, conclude with the statement, "cured." We are not to understand from this that the use of chrysarobin, whether in the form of ointment or solution, was never followed by a relapse—but only that the existing symptoms had completely disappeared when the patient ceased attendance. It is possible that the relief afforded in many of the cases of psoriasis will be found, after a sufficient period of time shall have elapsed, to be of a permanent and thoroughly satisfactory character.—AUSPITZ; *Med. Klin. Wochenschr.*, August 4, 1883.

THE STUDY OF A VARIETY OF EXANTHEM OCCURRING IN THE COURSE OF TYPHOID FEVER.

1st. RUBEOLIFORM and scarlatiniform exanthems are sometimes met with in the course of typhoid fever.

2d. The precocious eruptions belong, as a rule, to the scarlatiniform variety of rash, while the late eruptions more often exemplify the type of rubeoliform exanthemas.

3d. It is particularly over the joints and on a level with the flexures of the large articulations that the eruption presents the greatest confluence.

4th. This erythema is not:

- a. A confluent eruption of lenticular reddish spots;
- b. A scarlatina occurring in the course of typhoid fever;
- c. A sudoral eruption;
- d. A medicinal eruption;
- e. A diathetic eruption, rheumatism, syphilis, etc.

It appears to depend upon the typhoid fever, and to be one of its direct complications.

Albuminuria appears to be quite frequently a concomitant symptom.

5th. The prognosis is favorable when there is no albuminuria; in the contrary case, it is grave.—P. LEMAIGRE, *Th. de Paris*, 1883.

CUTANEOUS ERUPTIONS IN PUERPERAL INFECTION, AND POLYMORPHOUS ERYTHEMA IN PARTICULAR.

1st. THERE are often observed in puerperal infection, as in the course of surgical septicæmia and certain infectious diseases, cutaneous eruptions of variable aspect.

2d. These eruptions take on the characters of ordinary dermatoses, and although observed in diverse conditions, they arise from the same origin, the same pathogenetic cause, *infection*.

3d. Sometimes confounded with scarlatina in lying-in women, sometimes described as an essential disease under the generic name of "scarlatinoid," they ought to be clearly distinguished from the first of these affections, and to replace the second in medical nosography under the name, appropriate in every respect, of *polymorphous or multiform erythema of puerperal infection*.—J. GENEIX, *Th. de Paris*, 1883.

THE EMPLOYMENT OF NAPHTHOL IN CERTAIN CUTANEOUS AFFECTIONS.

1. NAPHTHOL, introduced into dermatological therapeutics by Prof. Kaposi, of Vienna, is the base of certain pharmaceutical preparations which are unexceptionable; they are *inodorous*, and *they discolor neither the skin nor the clothing*.

2. By the employment of naphthol, managed with the precautions indicated by Kaposi, we have never observed *phenomena of intoxication* (albuminuria, coloration of the urine) *nor acute inflammation of the integument*.

3. In the treatment of *scabies*, naphthol has proven an *excellent parasiticide*, as noted by Kaposi and Guérin. It exerts, in addition, a modifying action, extremely favorable upon concomitant eruptions.

4. In cases of *pediculosis*, naphthol is efficacious without danger and of easy management.

5. Our conclusions relative to its value in the treatment of *psoriasis* do not conform to those of Kaposi. We have not obtained any satisfactory results.

6. In the *prurigo of Hebra*, it rapidly dispels the pruritus, and influences the eruption favorably, but exercises no more *curative action* than other well-known medicaments.—PAUL SOMBRET, *Th. de Paris*, 1883.

NON-PRURIGINOUS SCABIES.

1. PRURITUS may be absolutely absent in scabies:

a. In anæsthetic patients;

b. In patients preserving all the recognized characteristics of physiological cutaneous sensibility: it would seem that there exists a special sensibility to the acarus or to the acarian virus.

2. Non-pruriginous scabies is rare, but is more frequent than is generally believed, because one usually searches no farther than the objective signs.

3. It must lead to numerous errors of diagnosis, and the only means of avoiding them is to search for the acarian furrow when there exists a polymorphous eruption, even should there be no itching.—A. JOURARMAND, *Th. de Paris*, 1883.

Received.

Ueber Syphilis Maligna. Von DR. EDMUND LESSER. (Reprint.)

The Development of Cancer from Non-malignant Disease. By DANIEL LEWIS, M.D.

An Analytical Study of Two Thousand (2093) Consecutive Cases of Skin Diseases. By H. W. STELWAGON, M.D. (Reprint.)

Ueber den Arzneigelatinverband und die locale Behandlung des Ekzems. Von Prof. FIL. JOS. PICK. (Reprint.)

Multiple Neurome im Bereich des Plexus brachialis sinister, cavernöse Angiome, Lymphangiome und Neurofibrome der oberen Extremität. Von Prof. HEINRICH KÖBNER. (Reprint.)

Bericht der sýphilitisch-dermatologischen Klinik des Prof. EDUARD LANG. Innsbruck, 1883.

Ueber Immunität und Schutzimpfung. Von DR. SCHUSTER. Wien und Leipzig, 1883.

Hints on the Treatment of Some Parasitic Skin Diseases. By GEORGE H. ROHÉ, M.D. (Reprint.)

Pemphigus and the Diseases Liable to be Mistaken for it. By GEORGE H. ROHÉ, M.D. (Reprint.)

The Treatment of the various Forms of Acne. By GEORGE H. ROHÉ, M.D. (Reprint.)

On Chronic Skin Diseases Treated by the Waters of Aix-la-Chapelle. By DR. SCHUMACHER, JR. (Reprint.)

Der medicamentöse Aether und Alcoholspray. Von DR. P. G. UNNA. (Reprint.)

Aphorismen über Schwefeltherapie und Schwefelpräparate. Von DR. P. G. UNNA. (Reprint.)

Die chronischen Infektionskrankheiten der Haut. Von Prof. DR. A. NEISSER. (Reprint.)

Allgemeine Pathologie und Therapie der Haut. Von Prof. HEINRICH AUSPITZ. (Reprint.)

Ein Fall von acuter Nephritis nach äusserer Applikation von Naphthol. Von DR. EDMUND LESSER. (Reprint.)

Ueber die Applikation von Arzneistoffen auf die Haut in dünnen festhaftenden Schichten. Von Prof. HEINRICH AUSPITZ. (Reprint.)

Kurze Anweisung zum Gebrauch der Salben- und Pflastermulle. Von DR. P. G. UNNA. Kassel, 1881.

Vaccinal Eruptions. By ALEX. NAPIER, M.D. (Reprint.)

The Vienna School of Dermatology. By HENRY WILE, M.D. (Reprint.)

Der Tastapparat der Hand der menschlichen Rassen und der Affen in seiner Entwicklung und Gliederung. Von DR. ARTHUR KOLLMANN. Hamburg und Leipzig, 1883.

Item.

New York Dermatological Society.—At the September meeting of the Society, DR. GEO. T. JACKSON was elected a member, and under the rules becomes its Secretary. He will, in the future, report the proceedings of the Society for this JOURNAL, a task heretofore so acceptably performed by DR. ALEXANDER.

JOURNAL
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Original Communications.

CASES OF PSORIASIS AFFECTING THE PALMS.¹

BY

W. T. ALEXANDER, M.D.

IN view of the generally acknowledged rarity of psoriasis affecting the palms, I feel that no apology is necessary for occupying the attention of this Association with so trivial a matter as a report of three cases of this form of the disease, particularly as I am able to illustrate the subject by the presentation of admirable photographic representations of the lesions. The patients are at present all under my care in the dermatological wards of Charity Hospital, New York.

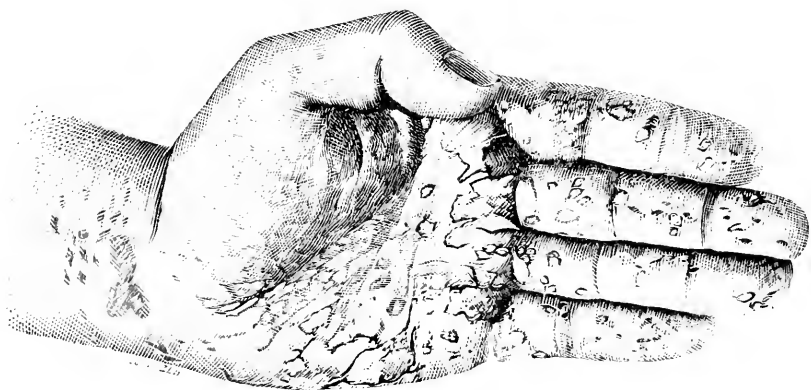
The first case is that of an Englishman, thirty-eight years of age. On admission, he gave the usual history of a disease of the skin appearing several years before, which always yielded to treatment, and as frequently relapsed, he having had in all six or eight attacks of it. For the one before that from which he now seeks relief, he was treated in this hospital with arsenic internally and a tarry ointment externally. He recovered in two months. In none of its previous outbreaks has the disease covered as much surface as now, and in none of them were the palms or the soles affected.

On examination, he was seen to be a well-developed man of healthy appearance, and said that he felt perfectly well with the exception of his skin disease. This covered his entire body—scalp, ears, face, hands, and feet all being involved. The lesions of the disease consisted of large and

¹ Read at the meeting of the American Dermatological Association, Aug. 30, 1883.

small, in many places confluent, sharply-defined, elevated patches covered with thick layers of dry, whitish glistening scales. These were being constantly exfoliated. On removing them forcibly, a bright-red surface, bleeding from numerous points, was exposed to view. Here and there islands of normal integument remained between the patches, the largest of which were on the buttocks and sides of the abdomen.

The palms of the hands and the corresponding aspects of the fingers down to their tips were covered with circular or irregularly-shaped bare spots, around which the epidermis was loosened from the corium for a short distance. Observation showed that these spots usually enlarged peripherally in all directions, and at no point could any evidence of infiltration into the corium be discovered. The denuded skin was of a reddish hue, less vivid than that under the patches on the body. No accumulation of scales ever occurred on the patches on the palms. On the backs of the hands and feet, the lesions presented the same appearances as those elsewhere on the body.



The patient admitted having had an attack of gonorrhœa a number of years ago, but absolutely denied ever having suffered from any other venereal disease.

The second patient was a German, forty-eight years old. In him the disease appeared twenty years before in the shape of a small scaly patch on the back. Although it always quickly yielded to treatment, it always recurred, eight or ten times in all. It now covers his whole body, with the exception of small patches of healthy skin here and there. It presents the usual characteristics of psoriasis, the patches being everywhere thickly covered with scales, so that the patient seems at a little distance to be covered with a coating of white paint. The palms of the hands and soles of the feet are also affected, though in a lesser degree than in the previous case, only twenty or thirty small circular scaly patches being present. The nails are likewise the seat of the disease, their surfaces being rough-

ened, some of them being loosened from their beds, and presenting a split condition of their free extremities, underneath which a large accumulation of epidermic scales is noticed. The patient denies ever having suffered from a venereal disease.



The third patient was an Irishman, aged thirty-seven years. His skin disease appeared twenty-five years before. He had been an inmate of the hospital eight or ten times, and had always been relieved of his affection. Thirty years ago he contracted two ulcers on his penis, "like boils," which soon healed, and were never followed by any syphilitic manifestations as far as he can recollect. In none of the previous attacks of the disease were his hands involved.

On admission, the disease was found to be chiefly confined to the dorsal aspect of his body, the largest patches being on the legs and buttocks, both aspects of the elbows, and the front of the forelegs. On the palms and soles were a small number of (usually) circular patches, some of pin-head, others of pea size. The epidermis is loosened around them, and on fresh spots the exposed surface is of a bright-red hyperæmic color. Not a trace of infiltration or thickening of the skin could be found.

In all of these cases the disease was an unmistakable, commonplace, typical psoriasis, so well-marked that any one of them might have served as an admirable model for an illustration for an atlas of skin diseases. In none of them could any evidence of syphilis either in the past or the present be obtained, and only one of them admitted having had venereal sores.

THE TREATMENT OF ECZEMA.

BY

DR. MCCALL ANDERSON.

(Concluded from page 434.)

THE *nails* are often implicated in the subjects of the eczematous taint (eczema unguinum), especially if the fingers are the seat of the disease. If those portions of the skin immediately behind the roots of the nails are affected, the corresponding nails are pretty sure to be involved. It is rare for all of them to be attacked, but frequently several are diseased, although in an unequal degree.

They first lose their smoothness and shining aspect, and become opaque, rough, and uneven on the surface, especially near their roots. If the disease advances, they become thick and brittle, and on this account do not grow to their normal length. In aggravated cases the nails exfoliate; but new and healthy ones generally grow in their place, if the morbid process is arrested by appropriate treatment.

The treatment does not differ from that of eczema of other parts, but local treatment must be directed principally to the skin surrounding the nails, and especially at their roots.

Eczema of the genital organs (eczema genitalium) occurs both in females and males. In the female the eruption may be limited to the labia, or extend upwards to the mons veneris, downwards and backwards to the perineum and anus, and laterally to the angles formed by the junction of the labia with the thighs. The vagina may likewise be implicated, in which case its walls are infiltrated, reddened, and exuding; but it is not the seat of any itching, except at the orifice of the canal. The labia and clitoris are often enormously distended, in consequence of copious serous infiltration, and the itching so harassing as sometimes to induce irritability of the bladder, and to lead to improper habits. At times the exudation from the eruption is great, at others the parts are dry and scaly. The local causes specially operating in the production of this variety of eczema are irritating discharges from the genital organs, the habitual warmth and moisture of the parts, and the friction of opposed surfaces. Pregnancy also, and tumors of the uterus and neighboring viscera, act as predisposing causes, by pressing upon the large vessels and causing passive congestion and a varicose condition of the veins of the genital organs. It must be borne in mind, too, that this form of eczema in particular (or, in some cases, pruritus only) often occurs as a complication of diabetes mellitus, and results apparently from the lowered tone of the system, and in the tendency in such persons to

low forms of inflammation, and sometimes partly from the irritation of the saccharine urine. "When you are consulted," wrote Trousseau, "by women who are becoming elderly, for intense itching in and around the vulva—when, on examining the parts, you find that there is eczema, and learn that it has come on irrespective of the menstrual periods, or of any leucorrhœal discharge, and that the pain it occasions is so great as to prevent sleep, the probable existence of glucosuria will suggest itself."¹

The following cases, and I could give many such, may serve to impress upon the reader the frequency and importance of this complication :

"Mrs. C., aged 56, was admitted into the Western Infirmary, Glasgow, on October 21, 1879, complaining of a scalding sensation about the labia and anus of about two years' duration. For twelve years previously—since the cessation of menstruation—she had been troubled with leucorrhœa, and for ten years had suffered from bronchitis, especially during the winter months. Two years before admission she began to remark that she had to make urine more frequently than formerly, and that it was excessive in quantity : this was shortly followed by an irritable condition of the orifice of the vagina, and in a short time the itching became exceedingly distressing. As the result probably of the scratching, the parts became very painful, and the seat of an eruption which extended from the vulva as far as the anus, these parts, as well as the skin at the flexures of the thighs, being red and excoriated.

From the commencement of her illness she had experienced great thirst, her appetite became ravenous, and she had a great desire for animal food.

For about nine months before admission she had some dropsy, especially of the lower extremities. She was a very rheumatic subject, and the dropsical and pulmonary symptoms were the result of mitral regurgitation induced, doubtless, by the rheumatism. On examining her urine it was found to be loaded with sugar. She derived great benefit from being put upon a diabetic diet, the parts being dressed with pieces of linen spread with oleate of lead ointment, and morphia suppositories being used from time to time."

On December 21, 1876, I was requested by my friend, Dr. Samuel Sloan, of Glasgow, to visit with him a lady about fifty years of age, on account of intolerable itching between the labia, accompanied by stinging and darting pains which prevented sleep and made her life miserable; it was of long standing. On examining the parts, nothing was to

¹ Lectures on Clinical Medicine, delivered at the Hôtel Dieu, Paris, by A. Trousseau. Vol. III., p. 503. New Sydenham Society, London, 1870.

be seen except that the skin was somewhat thickened and white as the result of the use of a lead lotion. She was a healthy-looking woman and well nourished: the skin was soft, and not drier than natural; her tongue was clean, her appetite moderate, and her bowels regular, but she had slight thirst, a circumstance, however, which was only mentioned when particularly inquired for. The urine was reported natural, but on examination it was found to have a specific gravity of 1025, and to contain an abundance of sugar.

In the *male*, eczema attacks the scrotum or penis alone, or involves also the neighboring parts, as in the female, or it may invade other and distant portions of the skin. The scrotum is often enormously distended, so as nearly to conceal the penis, producing a sort of elephantiasis of the parts, which is apt to mislead one as to the nature of the case. The skin is often very tense, red, perfectly smooth and shining, and the exudation profuse, dropping continually from the most dependent part of the scrotum, or soaking the dressings. In the early stage, burning heat is complained of; later, itching, which is usually excessive, and may lead to masturbation and irritable bladder.

In the more chronic variety, as pointed out by Hebra, the scrotum being thrown into folds, the eruption is often limited to the prominences of the folds, the intervals between each fold being free from disease, as may be seen by putting the skin upon the stretch. It sometimes happens that eczema of the genital organs is produced or kept up by stricture of the urethra, the cure of the eruption coinciding with the removal of the stricture.

Eczema is often limited to the anus (eczema ani), though it frequently extends to the neighboring parts, and, as before mentioned, it sometimes coincides with eczema of the lips (see eczema labiorum). The occurrence of the eruption at this part, as well as at the genital organs, is favored by constipation of the bowels, or gastro-intestinal derangement, by hepatic disturbance, tumors in the abdomen, or anything which prevents the free return of blood from the rectum. It frequently also coincides with a varicose condition of the veins of the rectum, and with hemorrhoidal tumors; hence the name eczema hemorrhoidale.

Sometimes the morbid condition of the anus is arrested in the first stage, and does not amount to an eczema, itching being almost the only symptom (pruritus ani), which is often very distressing. But in persons predisposed to eczema, the scratching calls forth an eczematous eruption, which is too frequently complicated by the formation of fissures, and these are exceedingly painful, especially at stool. Hence, on defecation, the patient is apt to strain very much, just as in cases of dysentery, and prolapse of the rectum may result. If care is not taken, this affection may be mistaken for phtheiriasis pubis (the disease due to crab lice); for

the latter do not limit their attack to the hair of the pubes, but often implicate all the neighboring hairy parts, including the anus. But a careful inspection will lead to the discovery of the nits of the parasite, or of the pediculus itself clinging to the hair on the level of the skin.

The treatment of eczema of the genital organs and anus does not differ from that of eczema in general, except in so far as we must bear in mind the predisposing causes, and endeavor to remove them, if possible. I must refer the reader, therefore, to the treatment of eczema in general, and to the remarks about to be made with regard to the treatment of eczema intertrigo.

Eczema not unusually attacks *the nipples* and neighboring portions of the breasts (eczema mammae), the nipples being commonly situated in the centres of the patches. The eruption occurs oftenest in the female, in connection with lactation, and chapped nipples constitute, in reality, the commencement of the fissured variety of eczema (eczema rimosum). In males, or in females who are not nursing, the detection of an eczematous eruption upon the nipples should lead us to suspect that it is brought out by the scratching induced by an attack of scabies, and the acarus and its accompanying symptoms should be sought for. Eczema of the mamma is apt, by extension of the inflammation to the deeper-seated parts, or by the sympathetic irritation which it sets up, to give rise to abscess of the breast.

In 1874, Sir James Paget¹ described a disease of the skin of the breast which he suspected to be of the nature of eczema, but which always, in his experience, ended in cancer of the mammary gland—a malady now pretty generally known under the name of “Paget’s disease of the nipple.” “I believe,” he writes, “it has not yet been published that certain chronic affections of the skin of the nipple and areola are very often succeeded by the formation of scirrhus cancer in the mammary gland. I have seen about fifteen cases in which this has happened, and the events were in all of them so similar that one description may suffice.

“The patients were all women, various in age from 40 to 60 or more years, having in common nothing remarkable but their disease. In all of them the disease began as an eruption on the nipple and areola. In the majority it had the appearance of a florid, intensely red, raw surface, very finely granular, as if nearly the whole thickness of the epidermis were removed; like the surface of very acute diffuse eczema, or like that of an acute balanitis. From such a surface, on the whole or greater part of the nipple and areola, there was always copious, clear, yellowish, viscid exudation. The sensations were commonly tingling, itching and burning, but the malady was never attended by disturbance of the gen-

¹St. Bartholomew’s Hospital Reports for 1874. p. 87.

eral health. I have not seen this form of eruption extend beyond the areola, and only once have seen it pass into a deeper ulceration of the skin after the manner of a rodent ulcer." . . .

"I am not aware that in any of the cases which I have seen the eruption was different from what may be described as long-persistent eczema, or psoriasis, or by some other name, in treatises on diseases of the skin; and I believe that such cases sometimes occur on the breast, and after many months' duration are cured, or pass by, and are not followed by any other disease. But it has happened that in every case which I have been able to watch, cancer of the mammary gland has followed within at the most two years, and usually within one year. The eruption has resisted all the treatment, both local and general, that has been used, and has continued even after the affected part of the skin has been involved in the cancerous disease." . . .

"In practice, the question must be sometimes raised whether a part through whose disease or degeneracy cancer is very likely to be induced, should not be removed. In the member of a family in which cancer has frequently occurred, and who is at or beyond middle age, the risk is certainly very great that such an eruption on the areola, as I have described, will be followed within a year or two by cancer of the breast. Should not, then, the whole diseased portion of the skin be destroyed or removed as soon as it appears incurable by milder means?"

It is of the utmost importance to come to a conclusion as to whether the disease in question is an eczema at first and is followed by cancer, or whether the former is in reality of a cancerous nature from the outset, although it bears some resemblance to eczema—whether regard be had to prognosis or treatment.

The following is my view of the matter. In persons predisposed to cancer, any local irritation may determine an outbreak of the disease at the part irritated: thus I have frequently seen an undoubted syphilitic disease of the tongue followed by cancer of that part, as the result of the long continued irritation, and just in the same way it is possible for a simple eczema of the breast to prove the exciting cause of, and to be followed by cancer of the mammary gland. But if we exclude these exceptional cases, I can come to no other conclusion than that 'Paget's Disease of the Nipple' is from the first of a malignant nature, and bears a somewhat similar relation to cancer of the breast that the so-called Tylosis (or Psoriasis) linguæ does to epithelioma of the tongue. This opinion is supported by the microscopic examination of the diseased structures made by Dr. Thin and others. That gentleman "believes that the evidence points to a slowly advancing cancerous change near the mouths of the lactiferous ducts, which at a very early stage leads to irritative effects in the superficial tissues of the nipple and surrounding

skin, and eventually penetrates into the substance of the mammary gland.”¹ Such being the case, it is of the utmost importance to distinguish true eczema of the breast from ‘Paget’s Disease of the Nipple,’ towards which the following table may be of assistance :

<i>Paget’s Disease of the Nipple.</i>	<i>Eczema of the Nipple and Areola.</i>
1. Occurs especially in women who have passed the grand climateric.	1. Occurs especially in women earlier in life, and particularly during lactation, or in persons laboring under scabies.
2. Affected surface, in typical cases, of brilliant red color, raw and granular looking after the removal of crusts.	2. Surface not so red and raw-looking, and not granular, but often punctated.
3. When grasped between the thumb and fore-finger, superficial induration often felt, as if a penny were laid on a soft, elastic surface, and grasped through a piece of cloth. (Thin.)	3. Soft, and no induration.
4. Edge of eruption abrupt and sharply-cut, and often elevated.	4. Edge not so abrupt, and certainly never elevated.
5. Very obstinate, and only yields to extirpation or other treatment applicable to epithelioma generally.	5. Although sometimes obstinate, yields to treatment applicable to eczema.

It is not necessary to give any special details with reference to the treatment of eczema of the breasts, further than to call attention to Hebra’s statement that, “when the disease is situated in the nipples, it is usually very obstinate, so as to resist the action of oleaginous and alkaline and tarry applications, and, sooner or later, to render necessary the use of more caustic remedies, such as solutions of corrosive sublimate (gr. v. ad \mathfrak{z} i.), or of potash (\mathfrak{z} ss. ad \mathfrak{z} i.). These may be used without fear of subsequent mischief; the excretory ducts remain patent, and the mamilla is as fit for its function as before.”²

Sometimes an eczema is developed around the *umbilicus* (eczema umbilici), especially in the case of those who are affected with scabies. In typical cases, the navel is much swelled and projects in the form of a small tumor, which is usually situated in the centre of the eczematous patch; otherwise, the disease here exhibits no peculiarities.

The eruption is exceedingly prone to invade those portions of the skin *which are in contact with one another* (eczema intertrigo), owing to their moisture and the friction to which they are exposed. We, accord-

¹ Quoted by Robert W. Forrest, M.D., in a communication to the Pathological and Clinical Society of Glasgow, May, 1880.

² On Diseases of the Skin, including the Exanthemata, by Ferdinand Hebra, M.D., Vol. II., p. 172. New Sydenham Society, London, 1868.

ingly, find it very frequently in the axillæ, between the pendulous mamma and the chest, between the hips, at the angle where the thigh meets the perineum, behind the ears, and between the folds of skin observed on the abdomen and other parts of corpulent persons. For similar reasons, we find it often on the flexor surfaces of the joints, these parts being in contact with one another in certain positions of the limbs.

In such cases, we must wash the parts frequently, but dry them thoroughly after each ablution. The opposed surfaces of skin must be kept separate also, so as to prevent friction and the accumulation of the exudation, for which purpose a piece of dry lint may be inserted between them, care being taken that it separates the parts completely, and that it is smoothly applied and frequently changed; else, it becomes soaked with the discharge, acts as an irritant, and does harm instead of good. It is very useful, also, before applying the lint, to dust the parts with one of the absorbent powders previously referred to. The powder absorbs the excessive moisture which, along with the friction of the opposed surfaces, is the exciting cause of the disease. The drying up of the moisture and the prevention of friction are often, of themselves, sufficient to effect a cure, especially if the attack is not a severe one; but if these means fail, the treatment recommended for eczema generally must be superadded. I have only further to add that in this form of eczema the use of Beiersdorf's Emplastrum Zinci is of especial value, and often acts like a charm.

Society Transactions.

NEW YORK DERMATOLOGICAL SOCIETY.

139TH REGULAR MEETING.

DR. P. A. MORROW, *President, in the Chair.*

PRESENTATION OF CASES.

DR. BULKLEY presented three cases of

EPITHELIOMA.

The first patient was a woman, sixty years of age. She was first seen in February, 1883. The disease resulted from local injury, she having fallen upon her face, sustaining a number of cuts. All of these healed excepting one on the nose and left cheek. When first seen, there was an ulcerated infiltrated mass with hard edges, about the size of the thumb, upon the nose, and another about one-half inch in diameter, with everted, hard, and pearly edges, upon the left cheek. These were erased with the sharp spoon, the resulting surface covered with powdered pyrogallie acid, and poulticed. Upon the cheek she now has a smooth cicatrix. The nose has been scraped two or three times. It healed over till two

months ago with apparently no trouble. Then there appeared some small points of granulation near the edge of the scar, which broke down. This was scraped again and again, and is now healing. He is still continuing the poultices, which he keeps up until the bleeding and the fungous appearance of the granulations have stopped. He called especial attention to the use of pyrogallic acid in these cases. It produces but little pain and sloughing.

The second case was a man, seventy-six years old. No history of cancer in the family, either near or remote. Twenty years ago a small wart first appeared below the right eye. He received a blow upon it, after which it ulcerated. In 1875, it was destroyed by caustics; it healed, and was well one year. Five years ago, Dr. Willard Parker removed it by operation, forming the flap from the forehead, after which it healed. In a few months, the disease again appeared. At present, the entire lower lid is destroyed, and the ulceration extends into the post-nasal cavity. Upper lid is thickened. The eyeball is intact. There is but little pain, and some numbness.

The third case was that of a man, fifty-six years old. He had always had good health. Twelve years ago, he was thrown from a carriage, sustaining a wound on the left eyelid, which healed readily. Nine months ago he had a severe neuralgia in the left side of his face, which was very persistent and recurring. In July, thinking that the trouble might be with his teeth, he had a few extracted, when the dentist discovered extensive disease of the upper jaw. The ulcerative disease soon broke through the left cheek, carrying everything before it, and has kept on extending. The patient presents an immense fungating growth, involving the whole side of the face, shutting up the eyes, with a large cavity leading into the antrum of Highmore. The jaw is ankylosed, and the upper lip is eaten away as far as the median line. He has, of himself, been using internally clover tea, and externally sheep sorrel. The sorrel has lessened the fetor. The case is remarkable for the rapidity of growth.

DR. FOX presented two cases of

LUPUS VULGARIS,

which he was treating by scarification.

The first patient was a woman, twenty-six years old. The disease had existed since childhood. It was excised once, and subsequently hydrastis had been applied, which caused it to ulcerate. It covers the right side of the face, below the eye, beginning on the nose.

The second patient, also a woman, forty-five years of age, had had the disease for fifteen years. It is on the left cheek, running across the face, about two inches long and three-fourths of an inch wide. About six months ago, a cutaneous horn began to grow upon the left side of the bridge of the nose, which was removed by the sharp spoon. The doctor drew attention to the comparative frequency of the occurrence of cutaneous horns and lupus upon the same patient.

DR. FOX further presented

A CASE FOR DIAGNOSIS BETWEEN LUPUS AND SYPHILIS.

The patient, a man, some twenty years ago was badly burned on the face. About three years ago a crust formed upon his nose, which he scratched. Ulceration began some five or six months ago. Now a large irregularly oval ulcer involves the end of the nose, extending more on the left side than the

right. The nose is enlarged and thickened. The man is well-nourished; color good; no history of syphilis or cancer to be discovered.

DR. BULKLEY then opened the

DISCUSSION ON LUPUS AND EPITHELIOMA.

He maintained that these were two distinct and isolated diseases; that they very rarely run into each other, and should not be confounded. The so-called "rodent ulcer" he regarded as a form of epithelioma. Lupus does not attack the deeper tissues, while epithelioma does, affecting bones and all.

DR. BRONSON agreed with Dr. Bulkley that lupus and epithelioma were two absolutely distinct diseases; but he believes that lupus is capable of eating deeply.

DR. PIFFARD thinks that both clinical observation and microscopical examination teach us that there is a deep lupus. He has had cases of deep ulceration on the face, with half a dozen other tubercles scattered over the face, consisting of rather large soft granulations unlike epithelioma. (Sections from some of these were examined at the meeting by Dr. A. R. Robinson, who pronounced them to be not epithelioma.) Multiple lesions are not common in epithelioma. The three prominent microscopical lesions of lupus are: 1st, Granuloma; 2d, granuloma accompanied with giant cells; and 3d, cell heaps. The prominent features of epithelioma are: 1st, a dipping down between the papillæ of the stratum Malpighii, the papillæ seeming to lengthen. This condition is not absolutely diagnostic of epithelioma, as we find similar appearances in psoriasis and eczema. The second and only characteristic feature of epithelioma is the accumulation of stratified cells in nests. In cases of deep ulceration prolongation of the mucous layer downward, or stratified cell nests must be present if they are epithelioma. In a number of cases of deep ulceration, he has found neither appearance, and therefore believes that there is a deep lupus extending lower than the skin. By its clinical features he would diagnose lupus, first, by its consistency. If we find the edge of the ulcer soft or of normal consistence, it is not cancer. If the edge is burrowed under, it is lupus. Second, by its duration. A duration of ten to twenty years is in favor of lupus. Lupus changes into epithelioma with considerable frequency.

DR. ROBINSON said that he had not examined many cases of rodent ulcer, but that in one case he found it to be a marked epithelioma. There is no similarity or special connection in process between lupus and epithelioma. Lupus consists in a change in nutrition commencing in the capillaries and in the lymphatic walls; in round-cell formation, not affecting either the upper part of the corium, the rete mucosum, or the corneous layer in its early stage. The process commences in the middle part of the corium. The cells are diffused or in heaps, and the walls of the blood-vessels are changed. The cells may undergo fatty degeneration, and disappear by absorption or ulceration; some may pass on to connective-tissue formation. We may have some with dilated nuclei like epithelioid cells, and even giant cells may be present. In a later stage there may or may not be growth downward of the interpapillary layer of the rete, and a passing on to epitheliomatous formation.

In epithelioma we have changes in the rete mucosum, at first a hyperplasia, then growth downward into the corium, and later heterogeneous changes. To constitute true epithelioma it is not necessary to have the cells undergo horny transformation. In the tubular or pavement form of epithelioma, the cells may resemble rete epithelium without horny transformation. At the margin of epithelioma the blood-vessels are dilated, and the circulation is normal.

When we find, in the early stage, a soft production in the corium, so that it can be easily broken up, without dilated blood-vessels running to the margin of the patch, or waxy-like margin, it is lupus. In epithelioma we find dilated blood-vessels, and a raised margin with waxy appearance on account of increase in epithelium. Epithelioma may occur secondary to lupus on account of slow, chronic, inflammatory changes in nutrition. Epithelioma would not produce lupus. All the deeper forms of ulceration are not necessarily epithelioma; in other words, there is a deep form of lupus.

DR. L. A. DUHRING, of Philadelphia, by invitation of the president, said that lupus presented marked clinical features, as also did epithelioma, though to a less extent. Rodent ulcer he regarded as one form of epithelial cancer. While he did not believe that lupus could attack the deeper tissues, yet there was a

form of ulceration which resembles that of lupus very much, and does involve the deeper tissues. This is a form of scrofuloderma. It is closely allied to lupus, and yet is different. In old cases it is probable that we cannot diagnose it from lupus by means of the microscope, and most of the cases we meet with are old cases. The difficulty arises from the great amount of inflammatory tissue present. As to epithelioma setting in after lupus, it does sometimes happen, but is merely a co-incidence.

DR. PIFFARD said that he named the case of deep lupus which he reported in his book on the skin, a "scrofulide." What we name lupus the French call scrofulide. In most cases of lupus there is phthisis in the family history. In deep lupus most all of the cases die of phthisis pulmonalis. He believes that lupus, more especially the deeper forms, should be called, "endothelioma," particularly of the lymphatics. Lupus is an infective disease, and its bacillus has been found and described. Lupus is perhaps a manifestation of tuberculosis of the skin.

DR. BULKLEY, in closing the discussion, said that lupus and epithelioma were two distinct diseases. Certain cases of lupus, after a time, can give rise to epithelioma and go deep into the tissues. But while lupus tissue remains as true lupus tissue, it has never gone deep. Tuberculosis of the skin he believes in. Scrofula can and does attack the skin as it does the bones. Eventually there will be a scrofuloderma recognized as distinct from lupus. In making a diagnosis of lupus, rhinoscleroma should always be taken into consideration.

Correspondence.

DERMATOLOGY AND SYPHILOGRAPHY IN FRANCE.

(From our Special Correspondent.)

DURING the months of April, May, and June, Prof. Fournier delivered a series of lectures, at the Hôpital St. Louis, upon LATE HEREDITARY SYPHILIS. In France, these lectures have attained a great celebrity, and I have thought that a succinct *résumé* might be of interest to your readers. While almost all the points developed by the eminent syphilographer were already known, yet, until now, they have never been so distinctly grouped, so carefully studied, and so rigorously discussed.

He commences by establishing the fact that the influence of hereditary syphilis does not manifest itself alone at birth, but is prolonged to a more advanced age; that it shows itself in infancy, in adolescence, and even later; and that it creates lesions of a grave character, often misinterpreted and referred to scrofula, and which demand mixed treatment.

In support of these propositions, he brings to bear incontestable facts: that of interstitial keratitis and double sarcocele in a child of four years, born of a syphilitic father, and presenting mucous patches, fifteen days after birth; that of cerebral syphilis cured by iodide of potassium, in a child of seven and one-half years, the offspring of a syphilitic father and mother; many other cases, equally confirmatory showing that tertiary accidents depending upon hereditary syphilis may manifest themselves during adolescence; finally, a case of double gumma of the tongue, in a man twenty-four years of age, who had had syphilitic sarcocele when sixteen years old, mucous patches a few days after birth, and whose mother was at that time under treatment for accidents of secondary syphilis.

The adult may also present accidents depending on hereditary syphilis; but Prof. Fournier does not possess the history of personal cases in which these lesions were observed in individuals of more than twenty-eight years of age. The existence of grave, profound, and *late* accidents depending upon hereditary syphilis obtrude themselves upon observation; why then insist upon always referring these lesions to scrofula or to acquired syphilis? Why refuse to syphilis acquired *in utero* that which every one accords to syphilis acquired by direct inoculation, viz., the faculty of presenting tertiary manifestations, long after the earlier symptoms have disappeared?

After having thus established the reality of late hereditary syphilis, Prof. Fournier shows that, in the great majority of cases, the subjects of hereditary syphilis have a special *habitus*, and present exterior signs which indicate the correct diagnosis. The principal exterior signs are, according to him, twelve in number. We shall pass them in review successively, and shall thus have a *tableau ensemble* of hereditary syphilis.

1. *Habitus et Facies*.—Hereditary syphilitics are, for the most part, delicate and of a poor constitution. They are thin; their muscular system is poorly developed; their complexion is pale, or rather grayish; their skin is dirty. They are distinguished, at a glance, from the scrofulous who have a fine, transparent, rosy skin, a voluminous upper lip, and bluish hands. It may be said, however, that these characteristics are far from being constant. Only a short time since, I saw, at the Hôpital Lariboisière in Paris, a young woman, twenty-two years of age, suffering from late hereditary syphilis, punctated keratitis, and irido-choroiditis, cured by mixed treatment. She had Hutchinson's teeth (median superior incisors), and yet she was remarkably well built, large, good-looking, and of a good complexion.

2. *Retarded and imperfect physical development* (infantilism). This patient was far from presenting the second sign of hereditary syphilis indicated by Fournier. Still, it must be recognized that hereditary syphilitics are often remarkable from the retardation and imperfection of their physical development. They walk and they talk late; their growth is slow, tedious, as if trammelled by an insufficient nutrition. They attain a stature below the average. Their virility is retarded or imperfect; their testicles are for a long time, in some cases always, rudimentary like those of a child; their beard appears as downy, blond, delicate, thinly scattered hairs.

In the female, the development of the breasts and the hairy system, the establishment of the menstrual functions are long delayed. This arrest of development may even go on to atrophy of the being, as in the patient spoken of by Rivington (*Med. Times*, 1872) who, at the age of sixteen years, had the appearance of a child of six. In a case of Lancéaux, there was no development of the uterus or ovaries.

Syphilis exerts, then, upon the human organism an action of arrest of development, and of marked dystrophia; it produces atrophy of a system, or a general atrophy; it leads to the debasement of the individual and the degeneration of the species.

These facts, interesting, but fortunately less frequent than Prof. Fournier would seem to indicate, have permitted him to once more affirm his opinion that syphilis produces not only syphilis, but that it exerts an influence upon the whole economy, determining a profound perturbation, and having for its consequences: anemia, neuroses, lymphatism, scrofula, tuberculosis, lupus, rickets—all of them affections which do not in the least resemble purely syphilitic manifestations.

3. *Cranial and Nasal Deformities*.—Certain cranial deformities are, according to Prof. Fournier, characteristic of hereditary syphilis; they are:

a. The Olympian Brow.—The forehead is higher and at the same time larger than normal; it projects forward in the same manner as a hydrocephalic cranium.

b. The Forehead with Lateral Bosses.—The forehead presents upon its sides small flattened, circular protuberances, quite similar to the bumps caused by contusions and due doubtless to osteophytes or hyperostoses.

c. Keel-shaped Forehead.—The forehead, flattened laterally, presents a median projection, like a rachitic thorax. Instead of being situated upon the forehead, these protuberances may be situated upon the sides of the cranium.

We may, then, recognize the four following varieties: *a. Lateral or Posterior Cranial Bosses*. These are small, bony projections. *b. Transverse Enlargement of the Cranium*. The biparietal diameter is increased; the biparietal bones are warped outward; there is sometimes a sort of depression at the level of the sagittal suture; this, in the adult, is a vestige of the *crane natiforme* of the infant (cranium simulating the buttocks) (Parrot). *c. Cranial Asymmetry*. *d. Hydrocephalic Cranium*. This last variety is exceptional; for, although hydrocephalus is frequently met with in hereditary syphilis, this grave complication is quickly followed by death.

The *nasal deformities* caused by hereditary syphilis are of two kinds:

(*a*). There are many which have a pathological past of epistaxis, discharge, *ozæna*, followed by the elimination of sequestra, then breaking down of the nose towards the age of eight, ten, twelve years. Some noses are broken down by destruction of their frame-work: sometimes it is the upper or bony part of the frame-work (nasal bone) which has disappeared; sometimes it is the inferior support (cartilages and septum); in the latter case, the inferior portion of the nose is retracted into the superior portion, forming what Professor Fournier picturesquely terms *un nez en lorgnette*.

(*b*). There are other nasal deformities less known, less apparent, but much more frequent, which only vitiate the organ without disfiguring the patient, and to which Hutchinson attaches the greatest importance. In this category should be classed the *noses snubbed* at their root, or simply the *noses flattened* at their base. These noses have no pathological past, the patient know not why they have them; it is quite probable that these slight deformities date from infancy.

4th. *Bone Lesions*.—These may consist in bony tumefactions situated either upon the *diaphyses* or upon the *extremities*. It is thus that one sometimes finds the head of the radius or ulna hypertrophied and voluminous, the malleolus projecting, the anterior extremities of the ribs presenting tumefactions like small marbles. Of all the long bones of the body the tibia is without doubt the one most often involved. It is swollen *en masse*, its anterior crest flattened, its surface transformed and studded with tuberos inequalities.

Bony lesions of a purely rachitic character have also been observed in hereditary syphilis (lateral flattening of the thorax, incurvation of the limbs, and sometimes, though rarely, curvature of the spine).

Professor Fournier has also been led to examine the question at present so disputed, of the relations of rachitis and hereditary syphilis. According to Dr. Parrot, rachitism is but a simple dependence, but one of the manifestations of hereditary syphilis; Professor Fournier is not so absolute; he admits, indeed, that rachitism is frequently encountered in patients affected with hereditary syphilis; but it is undeniable for him that rachitism may be observed in children whose parents are not, and never have been syphilitic. Instead of saying with Parrot

Rachitism = Syphilis, Fournier contends that syphilis may cause rachitism as it may create any other vital deterioration, that it is one of the principal causes, one of the principal affluents of rachitism, but that it is not the only cause.

5th. *Cicatrices of the Skin and Mucous Membranes*.—The cicatrices which should occasion a suspicion of hereditary syphilis are large and extensive; they may be polycyclic, they may be serpentine, serpiginous, and especially may they be circinate. They are situated (*a*) in the *commissures of the lips*, the child tears the commissures in crying when they are the seat of syphilides; (*b*) in the *nose at the angle of the nostrils*; (*c*) in the *lumbo-gluteal and posterior crural regions*, where they are so slightly marked and faint as to require a certain incidence of light in order to see them; they are whitish patches rather than true cicatrices; (*d*) finally, on the *arch of the palate and in the throat*.

6th. *Vestiges of Keratitis and Iritis*.—These important symptoms form with the lesions of the auditory apparatus and the alterations of the teeth, what may be conveniently designated as the *triad of Hutchinson*. The children of syphilitic parents are often attacked with interstitial keratitis and iritis at an early age. These lesions are obstinate and rebellious and leave behind them specks or opacities of the cornea of different dimensions, as albugo, leucoma, etc., and on the part of the iris, traces of inflammation of this membrane.

7th. *Troubles or Lesions of the Auditory Apparatus*.—These consist sometimes in purulent discharges from the auditory canal; sometimes in various lesions of the membrana tympani, determining either its total destruction or its perforation and leaving indelible cicatrices; sometimes in deafness of the strangest character, occurring without the slightest discharge, without febrile reaction, without inflammatory phenomena, without any pain, not explicable by any perceptible symptom. This deafness is then altogether special; it is uni- or bi-lateral and is developed with extraordinary rapidity—in two months, in three weeks, in fifteen days even, the patients cease altogether to hear, and this without apparent cause.

8th. *Lesions of the Testicles*.—Hereditary syphilis affects the testicles like acquired syphilis. There exists a syphilitic sarcocoele in infancy which may result in sclerous atrophy; it presents the three following peculiarities: (*a*) the testicles are small, retracted, and shrivelled; (*b*) they are hard—of a woody cartilaginous hardness; (*c*) they are irregular in form and sometimes studded with small nodosities.

9th. *Ganglionic Hypertrophies*.—This phenomenon is quite frequently met with in patients with hereditary syphilis; upon the neck in particular, there may be found chaplets of ganglia more or less confluent.

10th. *Arthropathies*.—The arthropathies of hereditary syphilis may take on two forms:—that of indolent chronic articular effusions, a sort of hydrarthrosis without any inflammatory or painful reaction, from which patients do not suffer and from which they do not ask to be cured; (*b*) that of deformatory arthropathies, leading to bizarre deformities, prominent osteophytes, vicious attitudes, etc., the vestiges of syphilitic arthritis of early infancy, dry arthritis, sometimes even suppurating arthritis.

11th. *Arrest of Intellectual Development*.—The offspring of syphilitic subjects are often affected with intellectual disorders. Sometimes they have a limited, obtuse intelligence, they do not begin to talk until late, they learn to read with difficulty, they are always the lowest in their class; sometimes they are complete idiots, scarcely comprehending what is said to them, or even not comprehending anything. Their life is limited to acts purely instinctive.

12th. *Dental Malformations*.—Syphilis may retard the development of the dental system, but it specially modifies its structural development. These alterations may be grouped under the four following heads: (a) *dental erosions*; (b) *microdentism*; (c) *dental amorphism*; (d) *dental vulnerability*.

These consist not only of congenital malformations, of defects of development. The teeth have experienced the effect of general malaise impressed upon the general organism by syphilis when they were in process of formation. These alterations may affect both dentitions (Parrot), but they are especially manifest in the second dentition; ordinarily they are multiple and generally affect homologous teeth symmetrically.

A. *Dental Erosions*.—Under the term dental erosions, are designated alterations of the crown which seems worn, tapped, worm-eaten, as if notched by a file or eroded with an acid; there is, however no loss of substance; the tooth has been formed such as it is. These lesions are multiple in aspect, one may, nevertheless, discern several types.

α. *Erosions en cupule*: erosions called *cup-shaped*. Small excavations, or rather small cups of variable dimensions (pointed or pin-head), single or multiple, sometimes ranged in duplicate.

β. *Erosions en sillon (teeth striated or sulciform or furrowed transversely)*; the tooth is dirty, blackish at the level of the groove which is single or multiple (forming a sort of shelving), superficial or profound.

γ. *Erosions en nappe*: the widened grooves occupy a large surface, sometimes even the entire height of the tooth (*honey-combed tooth*) so that the face of the tooth presents alternations of projections and depressions.

B. *Erosions which occur on the summit of the tooth*.—The tooth then seems to be composed of two parts: I., a normal, healthy base; II., a small atrophied, deformed summit, around which the enamel is not developed. Surmounting this healthy base, from which it is separated by a deep depression, it seems to be a sort of dental stump arising from another tooth. Later, this stump, exposed to the action of foreign bodies, becomes broken, crumbled, and finally disappears; the molars become short, flattened teeth, without cuspids (*dents en plateau*), the canines present on their summit a sort of V-shaped erosion. The incisors may offer many types.

Sometimes there is an angular V-shaped notch on their free border.

Sometimes there is a series of notches (tooth like a saw).

Sometimes the tooth seems nibbled (tooth with broken summit).

Sometimes, finally, there is found a semi-lunar deformity, a type known under the name of the *Hutchinson tooth*.

The last lesion is by far the most important, and which is, so to speak, characteristic of hereditary syphilis. It consists of a crescentic or nail-shaped semi-lunar indentation, situated upon the inferior portion of the tooth, which presents at this level a loss of substance as if it had been removed like a chip. It is almost exclusively encountered in the two upper median incisors. Its regular and symmetric curve does not permit it to be confounded with a breakage of the tooth, nor with the indentation consecutive to the use of the pipe. Parrot has shown that it may be met with in the first dentition.

It may be said that the Hutchinson tooth presents certain accessory characteristics; its corners are gracefully rounded, it has its free border bevelled at the expense of its anterior face; it is often short, straight, so that the median upper incisors are smaller than the lateral. Sometimes it is enlarged at its superior, contracted at its inferior part, finally, its implantation is often vicious, two sym-

metric teeth have their axes convergent instead of parallel. The Hutchinson tooth does not always have these typical characters; at the moment it emerges from the gum it may present at the level of the notch small spines, which are only the atrophied summit of the tooth, and which are worn out and disappear after a certain time. After the thirtieth year, the Hutchinson tooth, properly so-called, is no longer met with, for the lateral parts of the notch are worn down, the hollow becomes less and less pronounced, the inferior border more and more rectilinear; the bevel even becomes finally effaced.

Professor Fournier next examines into the value of the dental erosion as a sign of hereditary syphilis. It is well known that Magitot contends that this lesion is of eclamptic origin, and that it is observed in subjects who have had convulsions during their early childhood. He has been able to establish even a certain chronological relation between the erosion and the age when these convulsions occur. We must admit with him that certain dental erosions are the consequence of infantile convulsions: but is eclampsia the unique cause of dental erosion? Certainly not, since there are many persons who have dental erosions that have never had convulsions. On the other hand, the fact that many of the subjects were born of syphilitic parents is thought to incriminate syphilis. This is the doctrine of Hutchinson revived and exaggerated in France by Parrot, who regards every dental erosion as due directly to syphilis.

Thus generalized, this proposition cannot be admitted. Many children present dental erosions whose parents have never had syphilis; dental erosions are found among animals which are absolutely refractory to syphilis.

It seems logical, then, to admit, with Professor Fournier, that the dental malformations known as erosions are common ordinary lesions, susceptible of being derived from the most diverse causes, as convulsions, syphilis, chronic enteritis, rheumatism, etc., especially when these causes determine a marked disorder of the general health. But it is no less true that certain erosions are the special product of syphilis, and which constitute signs of the highest value in the diagnosis of hereditary syphilis. The Hutchinson tooth properly so-called, without being a symptom absolutely pathognomonic of hereditary syphilis, constitutes, nevertheless, a strong presumption. All the other dental erosions, the cup-shaped erosions and the transverse furrows in particular, have no important signification from the standpoint of syphilis.

b. Microdentism.—This name is given to a malformation of the tooth characterized by a reduction of its volume. It is short, narrow, minute, lessened in all its diameters. This deformity may exist in all degrees: sometimes scarcely appreciable, it may arrive at what has been termed *dental dwarfism* (dwarf tooth).

C. Dental Amorphism.—The teeth may lose the type of the species; a canine may become similar to an incisor, and inversely, etc. They may cease to resemble any dental type and be really deformed (obliquity of the free border, transverse or vertical fluting, form of a small horn, of a peg, etc.). Dental amorphism, like microdentism, is almost always partial, that is to say, it does not affect the totality of the teeth.

D. Dental Vulnerability.—The teeth thus modified are much more prone than the others to ulterior degeneration, to a rapid wearing out of the superior portion, to caries, to precocious decay. Such teeth are essentially vulnerable because they are poorly protected: the layer of enamel is altogether incomplete, the enamel itself is friable, chalky, but slightly adherent, and becomes easily exhausted. Moreover, these teeth are diseased. Magitot has demonstrated that when there exists a furrow upon a tooth, this lesion propagates itself through the entire thick-

ness of the tooth; in the place of the normal dentine there is what dentists term globular dentine.

Professor Fournier has also strongly insisted upon the *irregularity of implantation and arrangement* of the teeth in hereditary syphilis. The spaces separating the teeth are much augmented, which give them a remarkably oldish aspect. In some cases necrosis of the maxilla is observed, and consequently the disappearance of certain teeth: quite frequently there is a symmetric absence of teeth, the canines and the pre-molars, for example, do not develop at all. There is then found a condition quite analogous to the *bar of the horse*.

All the dental malformations which have just been passed in review are, like the erosions, not pathognomonic of hereditary syphilis, since they are met with in persons whose parents have never had syphilis, they constitute, therefore, only a simple presumption.

After having thus exposed the picture of late hereditary syphilis, Professor Fournier has insisted upon two other very important elements of diagnosis which must be sought for outside the patient. These are :

1st. *The polymortality of children in syphilitic families.*—When parents are infected with syphilis, it is the rule that several pregnancies terminate successively in abortions or in children which, though born at term, succumb to a precocious death. In 441 cases which he had observed, only 100 children survived; 341 died; of these 341, 330 died within the first year.

2d. *Inquiry into their antecedents.*—This inquiry is, in Professor Fournier's opinion, necessary for the diagnosis of late hereditary syphilis. Without it there can be no absolute certainty. It is necessary to interrogate the parents of the patient, to examine them, to search for traces of syphilis, one should not trust to a simple denial on their part. We should also examine the direct collaterals of the patient, the brothers and sisters, for, in a family, as Hughlings Jackson has so well demonstrated, one child may present quite distinct evidence of hereditary syphilis, while in the others it is effaced, and the diagnosis is most difficult.

PARIS.

BROCQ.

Selections.

RHINOSCLEROMA AND ITS TREATMENT.

THE disease first described under this appellation by Hebra more than twelve years ago is still involved in considerable obscurity, both as respects its essential nature and its etiology. Recent investigations by v. Frisch have, however, done much to enlighten us on these points, by demonstrating the presence of a micro-organism within the tissues thus affected. Rhinoscleroma, therefore, can scarcely now be brought into connection with syphilis, although a certain general likeness is undoubtedly traceable between the two pathological processes. While, however, syphilis becomes a constitutional disease by means of an infection conveyed to every part of the system through the lymphatics and blood-vessels, in rhinoscleroma the morbid germs spread themselves from the nose as centre, by migratory cells, and through tissue-clefts only—on the one hand transforming the upper lip, the cheek, and sometimes the eyelid, into rigid plates with sharply defined borders, or sympathetically involving the superior maxilla, and

on the other, advancing in the direction of the palate, the pharynx, and the larynx, and subjecting these parts also to similar alterations.

On August 3, 1882, a case came under treatment at the author's clinic, in which (after Fowler's solution had been fruitlessly administered for several days) preparations of salicylic acid, and subsequently of carbolic acid, were resorted to, in accordance with v. Frisch's recommendation. The employment of these means resulted, not indeed in a complete cure, but in a very decided retrogression of the disease.

Hitherto, rhinoscleroma has bid defiance, not only to the use of absorbent remedies, including the entire list of antisyphilitics, but to operative procedures as well. Treatment, therefore, has been perforce restricted to removing the mechanical obstructions which result from alterations of tissue, by excision or cauterization of the morbid growths, and to forming an artificial opening, in place of the continually contracting oral aperture. (Billroth in one case was obliged to form a stomato-plastic operation every two years, and in another to enlarge with the knife a mouth which would scarcely admit the tip of his finger.) In some instances, stenosis has arisen from extension of the diseased process, and tracheotomy has become necessary.

Even from his own method, the author anticipates success only when the complaint is not too far advanced: it will prove as ineffectual as all others, if opposed to actual contractures of tissue and disorganizing changes.

The patient above referred to was a day laborer, a native of Poland, forty-six years of age. His general constitution was excellent, and he presented no traces of syphilitic or hereditary disease. The disorder for which he sought admission might possibly have originated in his having been run over, about a year previously, by a hand-cart, which, besides inflicting several bruises and abrasions, had severely injured his nose. The latter had been painful and greatly swollen; he was in the hospital for a month. He had since been well until about six months before applying at the clinic, when he became aware that his left nostril was closed to the passage of air. In this condition it had since remained; but, as he could give no precise account of the nasal swelling, and, in fact until he discovered the occlusion, was not aware of his disease, it is very doubtful whether the latter, with the resulting growths, was not really in existence before the accident occurred.

When the patient first presented himself, his nose was more than double its natural size—a disfigurement which was attributable to an infiltration occupying almost exclusively the right half of that organ. A tissue as hard as bone had formed upon the septum nasi, on the adjacent fold of the upper lip, and on the inside of the left ala nasi as far as the roof. The inferior border of the left nasal bone projected like a hard osseous ledge, and the fold running thence outward and downward toward the cheek was obliterated at its upper part. Only a slight bluish discoloration was observable on the skin, which was uniformly smooth, except where uneven excrescences protruded at the tip of the nose and the border of its left wing. The septum mobile and the rim of the left nostril were thickened to two or three times their normal size, and quite rigid; their free borders were lined with firm, pale excrescences, which also extended to the adjacent portion of the left upper lip. The left ala nasi, moreover, had two semi-lunar pieces cut out of its border, leaving between them a triangular projection. Within the left nostril, which was so greatly enlarged, appeared an excavated surface about the size of a bean, partly raw, partly scabbed over, through which there was no passage visible; a buttoned sound could hardly be

forced through the growths which composed it, as far as the choanæ, and the outer air was completely excluded. Both this obstruction and the semi-lunar incisions were the results of caustic applications. The right nostril was also considerably narrowed, but this was because the growths on the other side had pushed the septum in that direction. Pressure on the affected parts was painful. A space about as large as a dollar on the left side of the posterior pharyngeal wall was covered with a flat, indurated infiltration, bearing a whitish epithelium. This was only visible on lifting the velum palati. On both sides of the hard palate were similar, though smaller, protuberances, of a cartilaginous hardness. The naso-pharyngeal space was much too contracted to admit of a rhinoscopic examination, but on introducing the hooked forefinger behind the velum palati, both the choanæ were felt to be surrounded by solid masses that stood out prominently, especially on the right side. The lymphatic glands of the throat and neck were enlarged. There were no morbid appearances on other parts of the body.

The treatment employed was as follows. Its results were strikingly confirmatory of v. Frisch's opinion that micro-organisms are the true cause of the inflammatory phenomena in this complaint.

Parenchymatous injections every second day of a one-per-cent watery solution of salicylic acid (owing to their insolubility, the suspended crystals were injected directly into the tissues): afterwards, of a two-per-cent solution of salicylate of soda, a Pravaz syringeful being thrown in at several points on each occasion; the introduction into both nostrils of metal canulæ, which were wrapt in plaster, and powdered with salicylic acid; naso-pharyngeal douches of salicylate of soda; painting the rigid infiltrations within the nostrils, and on the choanæ, the posterior pharynx and the hard palate with an alcoholic solution of salicylic acid; snuffing up of salicylic acid, and insufflations of the same into the naso-pharyngeal space; the external application of a salicylic acid ointment, which was also forced into the nostrils with a spatula, in such quantity that it came out behind the velum palati; finally, the internal administration of two grams of salicylic acid every day for two and a half months.

The favorable effect of these measures was speedily apparent. Within ten days the sclerosed places, under the influence of the injections, had become softer and smaller; the rigid deposit on the posterior pharynx had diminished by one-half, while that on the hard palate had almost disappeared. Whether and how far the employment of the salicylic acid contributed to this result it is impossible to say with certainty.

Improvement, however, went on in this surprising manner for a few weeks only, after which the infiltration diminished in size at a much slower rate, and at some points continued nearly as hard as ever; the affected parts in and about the nostril (now no longer impervious), as well as on the hard palate and the posterior pharynx, which had in many places regained their former consistency, still presented here and there a few remaining callosities.

Consequently, on November 12, the salicylic was discontinued, and carbolic acid employed in its stead, in the same way, *i. e.*, as a one-per-cent solution for injecting, a two-per-cent ethereal solution for painting the parts, and a one-half-per-cent ointment.

A still further amelioration soon followed; but, as it did not extend to the excrescences in the neighborhood of the choanæ, an attempt was made on January 26 to inject these also, the canula being thrust between the hard and soft palates, through the velum, and into the infiltrated mass.

On February 4, however, the patient was obliged to cease his attendance, and nothing more could be done.

That a very decided amelioration in his condition had by this time been brought about is evident from a comparison of two woodcuts taken, one before the above-detailed treatment was commenced, the other in the month of December following. The nose in the latter is well-shaped, and on the whole presents quite a natural appearance. Nevertheless, it is difficult to decide whether the indurations that still remain should be regarded as cicatricial contractures (signs of a complete healing) or as scleromatous relics liable to further proliferation; it was impossible to apply the disinfectant remedies in such localities as the inside of the nostril, and the edges of the choanae, with the same thoroughness and certainty as to parts more easily accessible. But in any case of rhinoscleroma where *all* the morbid tissues can be reached and acted upon, the author is confident that his mode of treatment is capable of accomplishing a perfect cure.—PROF. E. LANG, *Wien. Med. Wochens.*, June 16 and 23, 1883.

GENERAL INDICATIONS AND RULES FOR THE USE OF SALVE- AND PLASTER-MUSLINS.

THE salve- and plaster-muslins have shown themselves to be a remarkably simple, efficient, and economical kind of dressing in the following diseases:

Circumscribed skin affections (including those which sometimes lead to disease, of other organs), such as require to be treated *without confinement of the patient*. Of course, these dressings are equally serviceable and convenient in universal cutaneous disorders and when repose in bed is necessary, but here they are less economical and simple, and consequently of less practical importance than some other methods.

Before their application, the diseased surface must be most carefully disinfected by the appropriate means. Hair must be cut or shaved off. Wounds and ulcers are disinfected with antiseptic water; when the skin is sound, or if it is thickened or exhibits scales or crusts, it is washed with a solution of *sapo viridis* or spirits of soap, sometimes preceded by bathing with oil. Highly irritable eczematous surfaces are washed with oil, or with a cooling mixture of oil and lime-water.

Next, pieces of bandage are cut off, large enough to cover the affected surfaces, to which they are caused to adhere by perseveringly smoothing them down from centre to circumference.

The dressing is best applied to the palms of the hands and soles of the feet by cutting off good-sized pieces of the material, on the anterior edges of which five slits are made for the reception of the fingers or toes. In like manner, the simplest way of fastening the dressing to the face or head is to cut holes in its lateral borders for the ears.

The places between the fingers and toes may be most securely bandaged by strips about an inch wide, having slits for the fingers and toes to pass through.

The fingers and toes themselves and the penis are conveniently covered by making turns around them with pieces about three-quarters of an inch wide, cut as long as possible.

This is all that is done with the plaster bands; dressings with the salve-muslins have to be finished, in most cases, by making close turns with a thin bandage.

On circumscribed portions of the face it will be sufficient merely to stick small pieces of salve-muslin, which are covered with corresponding bits of

bandage. The edges of the latter may be secured with a little collodion or water glass.

In the case of wounds, when the skin is not irritable and does not perspire freely in the cold season, etc., a more powerful effect can be obtained from this preparation by placing a layer of some impervious material (wax, gutta percha, parchment-paper) between the salve-muslin and the bandage.

In affections of the fingers, it is necessary that each one of them should be carefully and firmly enveloped.

In mild affections of the axillæ, and of contiguous surfaces of the thighs and scrotum, it is sufficient to place a piece of salve-muslin in the shirt-sleeves or the suspensory bandage; in severe cases, the application of a spica will be necessary.

On the region of the scrotum and anus, the application must be made at least once daily. In this situation much depends on the use of very elastic suspensory bandages, accurately and firmly adjusted, so as to hold the dressing in place during movement. A rather thick compress of linen or wadding, or a piece of gutta-percha paper, should always be inserted between the salve-muslin and the suspensory bandage.

For the urethral orifices and the auditory canal tubes must be made from salve-muslin in the following manner: A piece one to two cm. in length is cut from an ordinary india-rubber tube of suitable calibre; around one end of this is wrapped a piece of salve-muslin about four cm. square, in such a way as to supplement the India-rubber tube with one of salve-muslin projecting two to three cm. beyond it; the latter is then cut into three or four longitudinal strips. The india-rubber tube is placed in position with a gentle twist, and secured by bringing down the strips and fastening them to the adjacent skin. For the urethra these strips are always indispensable, but they are only needed in the day-time for the nasal-passages, and are quite unnecessary in the case of the auditory canal. If the little tube sits loosely in the orifice, it may be thickened by pasting on more salve-muslin.

Strapping the testicle with iodine plaster-muslins is done in the same way as Fricke's strapping with adhesive plaster (for particulars, vide *Ber. klin. Wochens.*, No. 28, 1881).—P. G. UNNA, *Monograph*, 1881.

[We have used the terms salve-muslin and plaster-muslin as translations of the words *Salbenmull* and *Pflastermull* used by the author. The preparations consist of a basis of loosely-woven muslin impregnated with the required salve or plaster.—EDS.]

LUPUS AND TUBERCULOSIS.

At a recent meeting of the Soc. de Biologie, M. Cornil described a very interesting series of experiments tending to show the infectious character of lupus, and the possibility of one day utilizing its products as a means of protection against tuberculosis. Sections of diseased skin from eleven lupus patients were subjected to microscopical examination. In all of them only one bacillus was discovered, and that one had appertained to an unmistakably tuberculous individual. Pieces from all the other ten specimens (free from organisms) were inserted into the peritonea of fifteen cobayes, and into the anterior chambers of the eyes of four rabbits. Only two of the cobayes were attacked with tuberculosis, and in them the disease was *developed much more slowly than usual*. There could be no doubt as to its nature, since it was reproduced in other animals of the same species by a series of inoculations.

Of the rabbits, two remained apparently uninjured, the third had a purulent

ophthalmia which was probably tuberculous, and the fourth suffered from lupus of the conjunctiva.

M. Cornil does not regard these results as warranting the conclusion that lupus, even if it be a tuberculosis of the skin, is identical with pulmonary tuberculosis, from which he thinks it is sufficiently differentiated by the slowness of its progress.

He intends next to inoculate the cobayes which resisted the lupus-poison with the most virulent tuberculosis, in order to see if these animals are still capable of contracting the latter disease.

He has not as yet arrived at a final judgment in the matter, but indulges the hope that, whether the malady engendered in his experiments shall prove to be a mild form of tuberculosis, or something which merely resembles it, as cow-pox resembles small-pox, it will yet furnish him with the means of combating the first-named scourge by means of vaccination.

M. Bert regarded M. Cornil's hypothesis a very probable one. Whenever an animal does not die from a poisonous inoculation, one of two things has happened. Either the intruding organism has been destroyed without producing any constitutional disturbance, or any morbid changes—that is, has remained simply inert—or else it has given rise to slight symptoms, and the animal is vaccinated. At all events, the problem of tuberculous vaccination can only be solved by such experiments as these of M. Cornil.—*Le Progrès Médical*, August 4, 1883.

ACTION OF HEAT UPON THE SIMPLE CHANCRE.

THE author was first incited to an examination of this subject by the remarkable results obtained by Prof. Chauveau in the same general field of inquiry, viz., the effects of heat in weakening and modifying organic poisons. The experiments now to be considered were conducted as follows: Chancrous virus was taken from different hospital patients under the author's care and placed in vaccine tubes, some of which were then subjected to various degrees of heat, while the remainder were preserved unchanged. Inoculations were performed with the heated and the non-heated virus, respectively, and their results compared.

In this way it was found that the virus of chancre becomes powerless when heated to between 37° and 38° (Cent.)—the average temperature of the interior of the human body.

The following are hitherto obscure points in the clinical history of chancre, which the author believes to be fully explicable in the light of this discovery:

1. The seeming impenetrability of the system by the virus of chancre, as evidenced by the non-occurrence of internal syphilitic ulcers and of pelvic buboes. The long-established fact that a chancrous infection never spreads to the interior tissues or beyond the superficial glands, can only be accounted for on the ground of heat. Admitting this, we can scarcely conceive the possibility of a pelvic abscess of venereal origin except in a subject whose central temperature had previously been lowered by exposure to long-continued and intense cold.

But if the infectious matter were able to withstand a heat of 40° or 45°, there would be nothing to prevent it from permeating the entire organism and furnishing the most fearful manifestations of its power.

2. The occurrence of bubo, whether chancrous or inflammatory, solely in the superficial glands. All the glands—superficial and deep-seated—are alike in structure and function; but the former, owing to their situation, preserve a lower tem-

perature, and this is the only conceivable reason why they alone are affected by bubo.

3. The brief duration of chancres on the cervix uteri, and the rapid changes which they undergo, are facts which should be considered from the same point of view; as also,

4. The limitation of chancre of the anus to the inferior portion of the latter.

5. The relative frequency of merely inflammatory bubo, which occurs almost as often as the chancrous form. It is a familiar fact that the same primary sore will give rise sometimes to a chancrous bubo yielding inoculable pus, and sometimes to a simple, non-infectious swelling. The author regards all secondary buboes as chancrous in their beginning, but thinks that an attack of fever will operate to convert any such bubo into one that is simply inflammatory.

Thus, he lately took charge of a patient laboring under syphilitic bubo. His bodily temperature was 39.2° , and by the aid of a hot bath was raised to 39.8° . The author then opened the bubo, and declared that it would turn out to be non-infectious. The result justified his prediction. The patient's rectal temperature at the time of opening the bubo was 39.2° ; the external temperature of the bubo itself, 37.6° ; that of its cavity, 38.5° .

6. Cure of phagedena by erysipelas. Erysipelas causes an elevation both of the central and local temperature, which may suffice to destroy the virulence of chancrous pus, and to transform the spreading ulcer into a simple one.

7. Cure of chancres by gangrene. The gangrenous process is uniformly accompanied by intense fever—sometimes passing into typhus—and itself results from a high grade of tissue-inflammation.

8. Difference in the results of inoculation in different regions.

This difference is well-known to experimenters, especially as connected with the question of syphilization.

In general terms, it may be said to depend on two conditions; 1st, the temperature of the inoculated locality, and, second, its higher or lower position on the bodily surface.

On the face, for example, which is raised highest and has an active circulation, chancres are of small size and heal quickly. But on the inferior extremities, whose temperature is lower, and is still further depressed by their dependent position, chancres are much larger and of longer continuance.

These facts show us how slight differences in temperature, when constantly maintained, may exert an important influence on the development of an infectious lesion, and, consequently, how the central heat of the body, although but little above the necessary point, may yet suffice to destroy the activity of such virulent elements as find their way into the more interior glands and tissues.

It is a natural inference from the above statements that in the employment of heat we possess an excellent means for the destruction of the syphilitic virus, and consequently for the treatment of chancre and its various complications.

We see, moreover, that in such treatment it is necessary to bring about an elevation of the central temperature, at the same time that we increase the external heat at the affected locality.

As to the best method of effecting this, the author's experiments, combined with those of others, have led him to the following conclusions:

The merely local application of heat by warm water does good, but is insufficient for the purpose.

General hot baths can hardly be endured long enough.

The sitz-bath, or, better still, the half-bath at 40° to 42° , may be supported for

hours together. It raises the central temperature high enough—to about 39° —while it increases the surface heat of the immersed parts.

In this way we may hope to destroy the syphilitic infection within a very short time.

It is certainly the best treatment for phagedena, and those obstinate chancres under the prepuce which cannot be reached by the usual applications.

Thus, too, every chancrous bubo may at once be transformed into a simple inflammatory affair, which, after its contents have been discharged by a single puncture, will heal without leaving a trace.

If the patient should be attacked by fever, it will be necessary to apply external heat by means of poultices, sand-bags, occlusion, etc., in order that the affected parts may maintain, as nearly as possible, the same temperature as the interior of the body.

If the author's theory be confirmed, it is likely, he thinks, to work a complete change both in the pathology and therapeutics of chancre and its accompanying complaints. He even ventures to hope that it may result in their entire extinction.—P. AUBERT, *Lyon Médical*, August 12, 1883.

RESCORCIN IN CUTANEOUS DISEASES.

THOUGH the author does not claim great experience in the treatment of diseases of the skin by resorcin, yet he regards the results he has attained as so uniformly good as to be worthy of reporting. In facial and "migrating" *erysipelas* he has used a two-per-cent solution of the drug locally with good effect. This, combined with the internal use of the same drug, in doses of four to eight grammes (60 to 120 grains) a day, when fever was present, caused a rapid deferescence, and checked the progress of the disease. In *wounds* of the skin and in vulvo-vaginal wounds following parturition, even when a diphtheritic process has been set up, resorcin in solution of ten per cent or less exerts a rapidly favorable action.

In a number of cases of *impetiginous eczema* of the head and face, he used the following ointment:

R Resorcin.....	1.0 to 2.0
Vaselin.....	10.0
Ft. unguent.	

This, after five to eight applications, caused the crusts to dry up and disappear, leaving a rosy spot. Where the crusts are very large, and on being removed show a denuded surface, this ointment being used the crusts form again in finer layers, and at last disappear. The serous oozing of eczema is also immediately checked by this ointment.

In *varicose superficial ulcers* he uses either the ointment or a two-per-cent solution with good effect. In exuberant granulations which bleed easily he uses pure resorcin instead of cauterizing with arg. nitrat. This produces a whitish or greenish eschar, cleans up the surface, and removes the exuberant granulations. For further treatment he applies compresses of one to two per cent solution. In some cases it is well to substitute a ten to fifteen per cent ointment for the lotion.

In a case of *epithelioma* of the skin he used the above ointment with a mitigating effect on the pain, a checking of the spreading, and a cleaning of the sore.

He believes that resorcin has a special affinity for the epithelial tissue of the

skin, improving its nutrition, modifying new formations, and destroying pathological new cells.—CATTANI; *Gior. Ital. delle Malattie Veneree e della Pelle*, 1883, Fscs. 3d, fo. 150.

THE ROLE OF SYPHILIS IN BLINDNESS.

SYPHILIS determines grave ocular lesions. It may produce blindness; it is a frequent cause of loss of vision; and this at any age—in infancy as well as in adult life.

All the membranes of the eye may be attacked with specific lesions, leading to destruction of the organ.

Most often the lesions are multiple; they rarely remain localized in a single membrane.

The ocular lesions of syphilis are most often indolent, and originate sometimes without the knowledge of the patient. Exception is made of iritis.

In the majority of cases, it is papillary atrophy which occasions the loss of vision.

Ataxia frequently shows itself in the syphilitic blind. Mixed specific treatment has considerable influence upon the ocular lesions of syphilis; a cure is quite frequent.—EDWARD BINET; *Th. de Paris*, 1883.

MORPHŒA ALBA.

MORPHŒA alba is a special cutaneous affection, characterized by more or less white indurated patches, surrounded by borders of a violaceous tint. In the early stages of the disease the patches are slightly elevated; later on they sink to the level of the healthy skin; and finally become slightly depressed.

The affection should be distinguished from scleroderma. It appears to depend on some trouble of the nervous system, probably of the trophic nerves. It tends to spontaneous recovery.—PAUTRY; *Th. de Paris*, 1883.

ZONA OF THE MOUTH.

DR. DESHAYES related, at the meeting of the French Association for the Advancement of Science, an interesting case of zona of the mouth, limited to the regions supplied by the lingual nerve and the inferior dental nerve, a branch of the inferior maxillary. The tonsils, floor and roof of the mouth, tongue, gums, the incisors, canines, and molars, the lower lip, and a portion of the skin of the chin were the seat of the pains, which, as regards the soft parts, were soon followed by the eruption. The teeth are at the present time—a year after the disease—entirely exempt from erosion, and no disturbance in the function of taste has taken place. The only probable cause of the affection was exposure to damp and cold. The patient was somewhat of a nervous subject, but exempt from any diathesis. The interest of the case especially resides in the fact that zona may affect several branches of a nervous trunk to the exclusion of others.—*Union Méd.*, August 28.

CORROSIVE SUBLIMATE IN GONORRŒA.

WHEN reading the recent articles upon the germicidal power of various substances, I resolved to try sol. of bichloride of mercury as an injection in gonor-

rhœa. Have recently treated two cases with it, curing them in from six to eight days completely. Strength of sol. used :

R Hydrarg. bichlor.....gr. i.
Aq. dest..... ʒ viij.

M. Filter. Sig.—Inject every four to six hours after urinating.—GEO. C. DOUGLASS; *Therapeutic Gazette*, Sept., 1883.

STIGMATA MAIDIS IN GONORRHŒA.

It is alike due to the drug as well as to my brother practitioners, that I report the unusual success I have had for several months in the treatment of gonorrhœa by fluid extract of corn silk (*stigmata maidis*). To me the treatment was quite novel, while it has been a great comfort to my patients to have their cases entirely relieved within a week, and very often in three days. In the cases in which I employed it, I depended alone upon the corn silk, and of course make no error in attributing success to that drug. A half-teaspoonful to a teaspoonful of the fluid extract three times a day will prove effectual in male or female.—LEO BENNETT; *Therapeutic Gazette*, Sept., 1883.

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